East Sussex
Drug and Alcohol Action Team
WORKING IN PARTNERSHIP TO TACKLE SUBSTANCE MISUSE

East Sussex

Adult and Young People's Drug and Alcohol Treatment Needs Assessment

2013

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Contents

EXECUTIVE SUMMARY

The East Sussex Drug and Alcohol Action Team (DAAT) is the multi-agency partnership that addresses drug and alcohol issues locally. The DAAT includes East Sussex County Council, local NHS organisations, District and Borough Councils, HMP Lewes, Sussex Police, Surrey and Sussex Probation Trust and providers and users of services. The DAAT involves a wide range of stakeholders through special interest groups.

From April 2014, the Drug and Alcohol Recovery Service (DARS) will provide effective recovery-focused treatment for adults across East Sussex. The service has been redesigned to help more clients recover from drug and alcohol use disorders. CRI provides the service, delivering services in partnership with a range of other organisations including Sussex Partnership NHS Foundation Trust, local GPs and pharmacists. The service works with offenders as part of the local 'Integrated Offender Management' (IOM) arrangements.

The Local Area Single Assessment and Referral Service (LASARS) assigns a complexity tariff using a locally agreed system based on client characteristics. The system will be established during the transition to the new service. The LASARS will confirm suitability for treatment, and allocate a complexity level to all clients who are referred for structured treatment. The complexity level will be allocated using the tools developed by Public Health England (PHE) (previously the National Treatment Agency) for use by the Drug and Alcohol Recovery Payment by Results (PbR) pilots.

This drug and alcohol treatment needs assessment considers the local situation of substance misuse treatment and service users in East Sussex. The purpose of the needs assessment is to identify gaps in the services provided, and unmet need. The document includes recommendations for improving treatment.

Adult Drug Treatment

There are an estimated 2,224 opiate and crack users (OCUs) in East Sussex. Between 1 April 2012 and 31 March 2013 (2012/13) we achieved a treatment penetration estimate of 68.6% (1525 of these OCUs were known to treatment). This means that there were approximately 699 OCUs who did not access treatment within the same period; broadly in line with the previous year.

A total of 1294 clients were receiving structured treatment from the Adult Drug Treatment Services in 2012/13, which is a slight increase on the previous year. The majority of the in-treatment population are male and in the 30 to 44 age group. Most people in treatment live in Hastings or Eastbourne, although there continues to be an increase in numbers for those individuals accessing the services from the more rural areas of the County. Half of those clients in contact with the criminal justice services are resident in Hastings. Almost a third live in Eastbourne.

When looking at their most recent episode, the majority of clients (58%) self-referred into treatment, a total of 267 (20.6%) clients were referred into treatment via a Criminal Justice route

Employment and housing remain crucial aspects in helping individuals sustain substance free lifestyles once they have been discharged from treatment. Although when compared to the national picture it is apparent that clients in East Sussex are less likely to report a housing problem, 15% of the total in-treatment population declared a housing need, which rises to 24% for criminal justice clients. This suggests that housing solutions need to be developed specifically for offenders.

Similarly, although adults in East Sussex seem more likely to be working, just below half of the in-treatment population also stated they are unemployed or unemployed and seeking work which rises to almost 6 out of 10 for the criminal justice cohort.

87% of clients in treatment in 2012/13 listed opiates and / or crack as a problem substance. While heroin continues to be the most common main drug declared by those accessing treatment, there has been a shift in other substance reporting patterns with cocaine (excluding crack) appearing as the next most prevalent primary substance. Reporting of this drug has increased by more than 80% since 2010/11. The 'test on arrest' initiative has identified cocaine users and engaged them in effective treatment since it was established in April 2011.

For most people, treatment is relatively quick. 68.3% of all discharges in 2012/13 were of people in treatment for less than a year. 12.2% of people who were discharged in 2012/13 had been in treatment for more than 4 years, which is more than 2011/12 (9.4%) and 2010/11 (5%). All clients within this group can be categorised as OCUs.

During 2012/13, 65% of adults in East Sussex completed their treatment journey and left in a planned way. This planned discharge rate remains higher than the national (47%) figure. However, the planned discharge rate varies with drug use. 9 out of 10 clients declaring cocaine as their primary substance and 8 out of 10 individuals citing cannabis, left treatment with a positive outcome.

Adult Alcohol Treatment

Prevention and treatment are part of a continuum of interventions to reduce alcohol harm. From a health improvement perspective our focus is engaging with people before they require treatment. Current prevention work includes targeted behaviour change interventions and 'Identification and Brief Advice' training for professionals. Specialist services treat dependent drinkers, and support people who are drinking at increasing and higher risk levels to reduce their drinking.

23% of the total adult population in East Sussex are estimated to be increasing and higher risk drinkers. Of those who are drinking, around 7% are doing so at high risk levels. It is estimated that there are 6,635 dependent drinkers in East Sussex with 13% of these in treatment.

Compared to previous years, there continues to be a shift in relation to drinking patterns, as there were more clients drinking between 1 and 199 units a month in 2012/13, and less drinking between 800 and 1000+. The proportion of clients drinking 1000+ units in the 28 days prior to assessment remains lower than the treatment population nationally (14%).

A total of 1336 clients accessed and received treatment for alcohol dependency during 2012/13. 62.2% of people in treatment are male. Activity to engage older drinkers in treatment appears to have had some impact.

Higher risk drinkers are more likely to start treatment in urban areas. Comparing the in-treatment population and the Local Alcohol Profile for England (LAPE) estimates, more than 10% of dependent drinkers in Eastbourne and Hastings have engaged with the alcohol service but fewer than 5% of dependent drinkers in Lewes and Wealden are accessing treatment. The Department of Health recommends that commissioners should plan for 15% of dependent drinkers to enter treatment each year.

During 2012/13, 69.6% of clients who exited alcohol treatment in East Sussex completed successfully, which is an increase on the previous year. Interestingly, the 60+ cohort have

the highest proportion of clients completing their interventions and leaving treatment in a planned way, and the lowest proportion failing to complete their treatment journey.

Young People

The numbers of young people in specialist substance misuse services in East Sussex has seen a year on year reduction. However, the proportion of young people in treatment as a proportion of the whole treatment population of East Sussex is still higher than the national picture and those young people in treatment appear more complex than previous years with a larger proportion having between 2 and 4 risks / vulnerabilities identified; this compares with YP identifying between 0 and 1 in 2010/11.

Locally, during 2012/13, the largest proportions of referrals were made via the Youth Justice route with 45% of referrals being made this way; higher than the national picture (34%). The planned exit rate for young people in the county remains high; 92% in 2012/13 compared to 79% nationally. Only 8% of clients who left in a planned way re-presented to treatment within 6 months which is also in line with national findings.

Novel Psychoactive Substances (NPS) has only recently become a drug category within the Public Health England dataset (from 1st April 2013), and as such, we do not currently have a robust mechanism for reporting usage of these substances locally. However, we are aware that the numbers of available NPS have seen a dramatic increase in recent years. It is therefore important that awareness of the availability, risks and effects of NPS are raised amongst professionals who may come into contact with people who use drugs i.e. GP's, A&E, teachers, probation, social workers, as well as the cohort of people who may be using, or thinking of using NPS, targeting schools, colleges and universities.

Families

National research estimates that there are 250–350,000 dependent children living with parental drug misuse[1] and 920,000 living with parental alcohol misuse [2] in the UK. If these estimates are applied to the East Sussex population on an equal share of the population this points to a potential for up to 7,000 children living with parental alcohol misuse and 2-2,500 living with parental drug misuse in East Sussex.

In 2012/13, local data shows that 50% of adult substance misuse clients reported having children, and 20% identified that they lived with all or some of their children. Of these 537 clients more than 50% were receiving treatment from Action for Change, 10% were receiving treatment from the SWIFT. The remaining 40% were receiving treatment from the Community Substance Misuse Teams.

In the same period, 2012/13, 9.3% of children placed on Child Protection Plans were identified as having alcohol abuse as a primary parental/carer risk factor and 5% were identified as having drug misuse as a primary risk factor.

[1] Advisory Council on the Misuse of Drugs, 2003
[2] Alcohol Concern 2000

RECOMMENDATIONS

1. Develop services that address the needs of NPS users, and/or those at greater risk of NPS
2. Communications about NPS to be targeted towards potential and current users and relevant professionals who may be in a position to refer and/or advise
3. DARS to monitor its clients use of NPS
4. Ensure that LGBT data is collected and analysed in order to target appropriate engagement activities
5. Increase the take up of DARS in rural areas by 25%
6. Implement a training programme to address the risk of accidental overdose
7. Review recording of 'alcohol as a secondary substance' to assess any emerging trends
8. Assess the impact of Welfare Benefit Reform with similar cluster areas
9. Ensure that all reviews of the DARS consider the impact of PbR
10. Ensure the clinical audit programme assesses the effectiveness of working with more complex clients
11. Ensure the clinical audit programme picks up active key working, access to psychosocial interventions and links to mutual aid.
12. Extend the range of aftercare, ensuring a wide range of activities and mutual aid are available for people completing treatment
13. Investigate ways to further promote safer injecting, reducing sharing and safer sexual behaviour
14. Benchmark BBV against other areas for clients assessed as 'not appropriate to offer'.
15. Ensure the clinical audit programme includes activities to reduce BBV
16. Work across the region to pick up best practice in increasing the take up of the full course of hepatitis B vaccinations
17. Investigate opportunities to develop closer working with community pharmacists who are more engaged in the NSP and supervised administration
18. Produce an annual np-SAD review.
19. Embed Serious Incident reviews into Treatment Performance Group to ensure that lessons are learnt and influence best working practice.
20. Review the care pathway from emergency care to DARS.
21. Review the needs of primary alcohol clients citing additional use of cannabis assess current practice to address this
22. Review clients accessing alcohol treatment to ensure the service addresses high and complex need
23. Ensure data collected through DARS captures protected characteristics and Gypsies and Travellers
24. Share 'Test on Arrest' analysis with partners, with the view of considering recommendations
25. Ensure that data from the prison service (on NDTMS) is used to shape improvements to services

1. Population

The 2011 census calculated the population of East Sussex at around 526,700, an increase of 34,376 people (+7%) since 2001. Just over 23% of the population in East Sussex is of pensionable age, an increase of nearly 1% from 2003.

Table 1: 2011 Census population by district

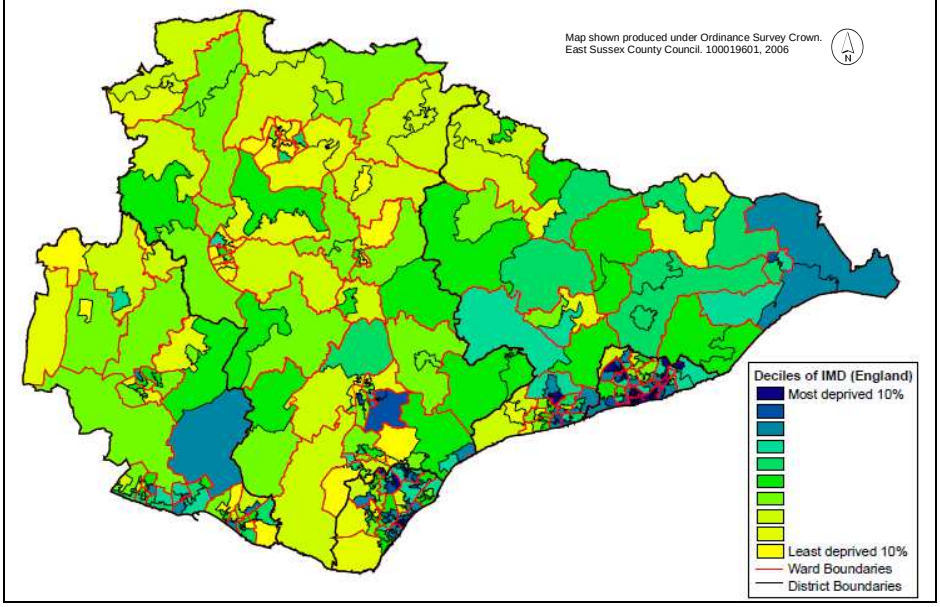
		0 to 14		15 to 29		30 to 44		45 to 64		65+	
	All Ages	No.	%	No.	%	No.	%	No.	%	No.	%
East Sussex	526700	85000	16.1%	83700	15.9%	90800	17.2%	147500	28.0%	119800	22.7%
Eastbourne	99400	15600	15.7%	18400	18.5%	18200	18.3%	24800	24.9%	22300	22.4%
Hastings	90300	15700	17.4%	17200	19.0%	17600	19.5%	24400	27.0%	15300	16.9%
Lewes	97500	15800	16.2%	14900	15.3%	16900	17.3%	27800	28.5%	22200	22.8%
Rother	90600	13200	14.6%	12000	13.2%	13000	14.3%	26500	29.2%	25700	28.4%
Wealden	148900	24600	16.5%	21300	14.3%	24900	16.7%	43900	29.5%	34000	22.8%

Much like the County as a whole, all five districts have a higher number of people aged 45 to 64 than any other age group. Wealden has the highest numbers of individuals in this age bracket, while Hastings and Eastbourne have the least. Also of note is that Hastings has the highest proportion of young people aged 0 to 14 (17.4%), followed by Lewes (16.2%).

1.1. Levels of Deprivation

The Deprivation 2010 (ID 2010) is a measure for deprivation in relation to the following factors: low incomes, lack of work, poor health, education, skills and training, poor housing and access to services, crime and poor living environment.

Map 1: Index of Multiple Deprivation 2010 – LSOAs in East Sussex



It is of note that East Sussex experiences the highest level of deprivation of all the counties in the South East. The county has 42 (13%) Lower Super Output Areas[3] which are ranked within the 20% most deprived areas in England. In the Indices of Deprivation 2010, nearly

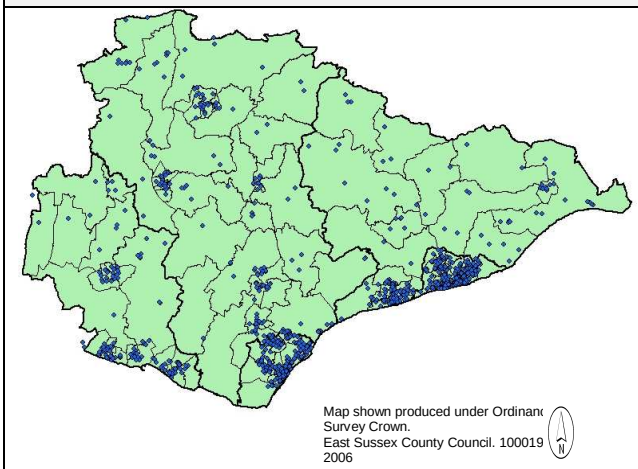
[3] LSOAs: Lower Super Output Area (LSOAs) are units of geographic boundary developed by the Office for National Statistics and are aggregations of Output Areas. Output Areas are subdivisions of 2003 wards and each contains approximately 125 households (300 residents). LSOAs are the next largest area up and each contain a minimum population of 1,000 persons and on average (mean) contain a population of 1,500 persons. There is a total 32,482 LSOAs in England: http://www.haveringdata.net/research/glossary.htm#L

three quarters of the LSOA's in East Sussex recorded a worse ranking than they did in 2007. This included 2 LSOA's that were in the most deprived 1% of the country. Both of these areas are in Hastings, in Baird and Tressell wards.[4] Outside of Hastings, 1 LSOA in Sidley ward in Bexhill was placed in the most deprived 5% in the country.

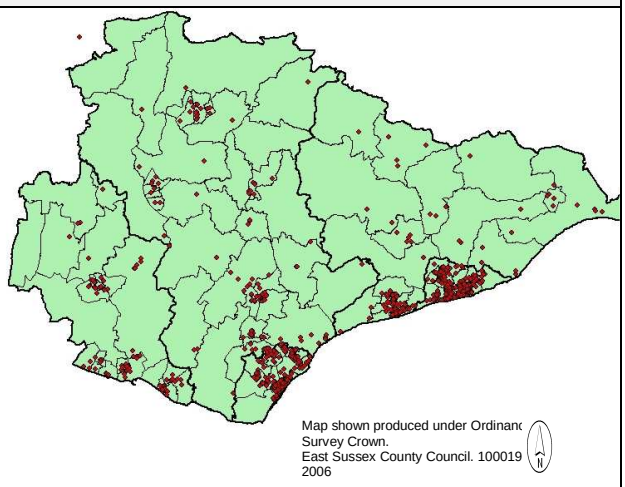
1.2. In-Treatment Population

As in previous years, the maps continue to show a strong correlation between the home addresses of the adult in-treatment alcohol and drug population and those in the most deprived areas of East Sussex. For the in-treatment drug population, the low numbers in the more rural areas, specifically Wealden, could also be due to their deprivation profile as a correlation has been made between drug misuse and deprived areas within the country. Wealden and Lewes have a low index of deprivation and Rother is also a less deprived area.

Map 2: Location of in-treatment alcohol population: 2012/13



Map 3: Location of in-treatment drug population: 2012/13



ADULT DRUG TREATMENT

2. Drug and Alcohol Recovery Service

From April 2014, the Drug and Alcohol Recovery Service (DARS) will provide effective recovery-focused treatment for adults across East Sussex. The service has been redesigned to help more clients recover from drug and alcohol use disorders. CRI provides the service, delivering services in partnership with a range of other organisations including Sussex Partnership NHS Foundation Trust, local GPs and pharmacists. The service works with offenders as part of the local 'Integrated Offender Management' (IOM) arrangements.

2.1. Complexity Placeholder

The Local Area Single Assessment and Referral Service (LASARS) assigns a complexity tariff using a locally agreed system based on client characteristics. The system will be established during the transition to the new service. The LASARS will confirm suitability for treatment, and allocate a complexity level to all clients who are referred for structured treatment. The complexity level will be allocated using the tools developed by Public Health England (PHE) (previously the National Treatment Agency) for use by the Drug and Alcohol Recovery Payment by Results (PbR) pilots.

[4] Out of the 16 wards in the district of Hastings, for those clients in treatment for Drugs in 2012/13, Baird accounted for 4.8% (ranked 7th) and Tressell 8.6% (ranked 4th). The Alcohol in Treatment population for 2012/13 is slightly less at 4.28% for Baird and 4.28% for Tressell. (ranked 8th and 9th)

The tools use information about each client's situation to allocate one of the following complexity levels:

- **Drug use disorder**: Very high / high / medium / low / very low
- **Alcohol use disorder**: High / medium / low

Data in relation to the complexity of clients in treatment will be reported in future assessments.

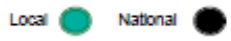
3. Public Health England: Joint Strategic Needs Assessment 2012/13

The data shows that in East Sussex, the number of completions and non-re-presentations for opiate and non-opiate users have increased when compared to the previous year. East Sussex has also seen growth in successful completions, for both opiate users and non-opiate users since 2011/12.

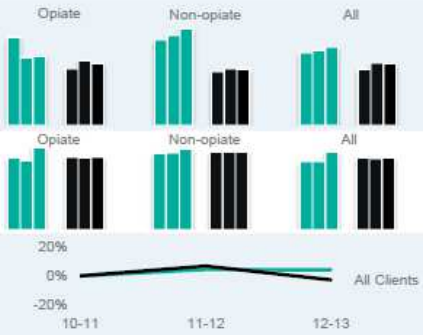
Key factors influencing your treatment outcomes 2012-13 compared to 2011-12

	Completions	Waiting times (proportion waiting under 3 weeks)	Non re-presentations
Opiate	▲ Up 1%	◀▶ No Change	▲ Up 14%
Non-opiate	▲ Up 5%		▲ Up 5%

Table 2: Trends in performance 2010/11 to 2012/13



		Local	National
Successful completions as a proportion of total number in treatment	Opiate	10%	9%
	Non opiate	70%	41%
	All	19%	15%
Proportion who successfully completed treatment and did not return within 6 months	Opiate	90%	80%
	Non opiate	99%	95%
	All	95%	88%
Growth in successful completions since 2011-12	Opiate	2%	-7%
	Non opiate	5%	2%
	All	4%	-3%



		Local	Proportion[1]	National	Proportion[1]
Number of adults new to treatment citing club drug use and opiate use	Ecstasy	0	0%	124	26%
	Ketamine	0	0%	150	32%
	GHB / GBL	0	0%	13	3%
	Methamphetamine	0	0%	25	5%
	Mephedrone	0	0%	175	37%
	Any club drug use[2]	0	0%	471	1%
Number of adults new to treatment citing club drug use (no additional opiate use)	Ecstasy	9	75%	966	31%
	Ketamine	1	8%	718	23%
	GHB / GBL	1	8%	218	7%
	Methamphetamine	0	0%	183	6%
	Mephedrone	1	8%	1,460	48%
	Any club drug use[2]	12	8%	3,070	12%

The JSNA also includes information in relation to the main 'Club Drugs' reported by new treatment entrants who are also using opiates (first table above) or using club drugs and other drugs but not opiates (second table above).

The document goes on to say that opiate users continue to be over-represented in adult treatment, and generally face a more complex set of challenges, are harder to treat and are less likely to leave treatment in a planned way. In contrast, non-opiate using, adult club drug users typically have good personal resources such as job, relationships and accommodation which all contribute to a successful treatment outcome.

4. Novel Psychoactive Substances

Novel Psychoactive Substances (NPS) has only recently become a drug category within the Public Health England dataset (from 1st April 2013), and as such, we do not currently have a robust mechanism for reporting usage of these substances locally. However, we are aware that the numbers of available NPS have seen a dramatic increase in recent years. The number of NPS reported by Member States to United Nations Office on Drugs and Crime rose from 166 at the end of 2009 to 251 by mid-2012, an increase of more than 50 per cent. For the first time, the number of NPS actually exceeded the total number of substances under international control (234)[5].

The Home Office are currently leading a review[6], with an expert panel, looking at how the UK's legislative response to new psychoactive substances, can be enhanced beyond the Misuse of Drugs Act 1971 to maximise its impact and the enforcement response to this new drugs market.

Anecdotally, local probation officers have started to notice individuals with a history of illegal substance abuse using NPS instead of controlled drugs. NPS can have a detrimental effect on mental health which can lead to re-offending. NPS also still need to be paid for and thus can be linked to offending in order to pay for them. Police and Probation have no legal powers to address this use, though for individuals on licence there is a move to consider addressing their use within the licence conditions.

Officers in Sussex Police have also noted the detrimental effect on young people. Anecdotally, they have reported that NPS tend to be readily available and as they are 'legal' there is no fear of prosecution. Before Mephedrone was controlled in April 2010, school and colleges reported seeing a marked effect on those students taking it. Levels of their concentration were dramatically reduced and some displayed aggressive behaviour.

It is therefore important that awareness of the availability, risks and effects of NPS are raised amongst professionals who may come into contact with people who use drugs i.e. GP's, A&E, teachers, probation, social workers, as well as the cohort of people who may be using, or thinking of using NPS, targeting schools, colleges and universities.

4.1. Khat

Khat is a herbal product consisting of the leaves and shoots of the shrub Catha edulis. It is chewed to obtain a mild stimulant effect. Khat is produced in the main growing regions of Kenya, Ethiopia and Yemen. Within Europe, khat use is primarily amongst BME immigrants from the Horn of Africa countries. Prevalence of khat use is far less among the Somali community living in the UK than in the population living in Somalia.

[5] World Drug Report 2013: https://www.unodc.org/wdr/en/nps.html
[6] Terms of reference for a review into legislative options to tackle new psychoactive substances: https://www.gov.uk/government/publications/terms-of-reference-for-new-psychoactive-substances-taskforce

Khat will be added to the list of drugs controlled by the Misuse of Drugs Act in 2014. Khat use is not known to be a significant issue in East Sussex. The control of khat is not likely to create any additional demand for help from drug treatment services.

Recommendation:
1. Develop services that address the needs of NPS users, and/or those at greater risk of NPS
2. Communications about NPS to be targeted towards potential and current users and relevant professionals who may be in a position to refer and/or advise
3. DARS to monitor its clients use of NPS

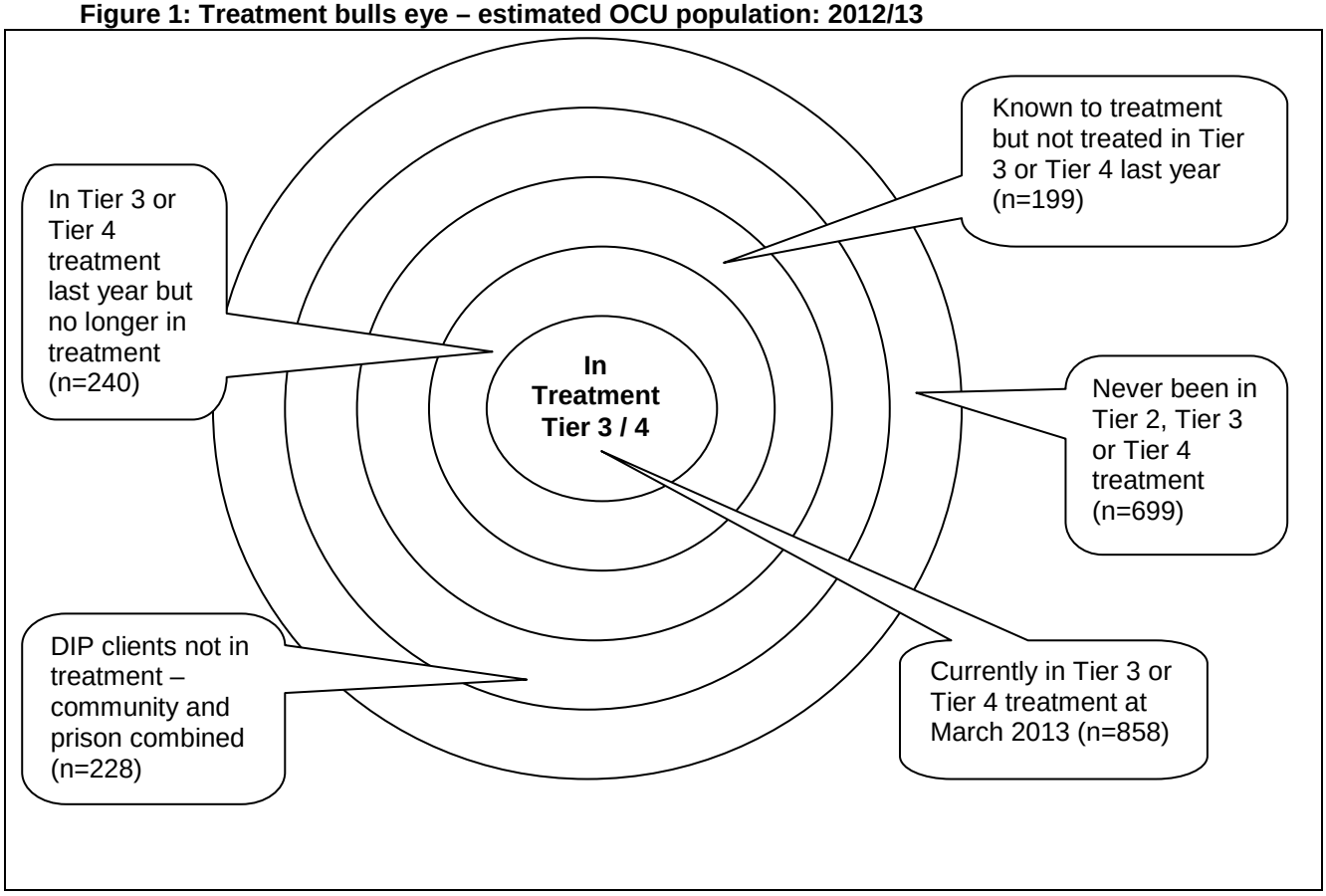
5. Treatment Map and Bulls Eye 2013

As stated in previous assessments, the treatment services use an integrated case management system, and individuals are in the majority of cases, in treatment with more than one service at any one time. Due to the integrated nature of drug treatment in East Sussex 'referrals' between treatment providers are not captured in a way that will serve the treatment map to be an informative process

5.1. Treatment Bulls Eye

As defined by the PHE, the treatment bulls eye is an illustrative way of defining and better understanding groups of Opiate and/or Crack Users (OCUs) based on their level of engagement with structured treatment. This approach uses two central sources, the NDTMS and Drug Intervention Programme (DIP) data, plus any other available local data to class the estimated OCU population by treatment status. The most dependable data will be found in the centre of the bulls eye, and the more unreliable data will be found in the outer rings of the circle.

Figure 1: Treatment bulls eye – estimated OCU population: 2012/13



6. Using the Revised Opiate and / or Crack User (OCU) Estimate

Based on the most recently published Hay OCU prevalence estimate of 2224[7] and using the information we know about our treatment population, including the 2012/13 NDTMS data we have estimated that about two thirds of the local OCU population are known to treatment services. Based on this, we can therefore estimate that there are 699 OCUs in the outer ring who are 'treatment naïve', which is broadly in line with 2012 findings that there 706 treatment naïve OCUs.

The tables below show the estimated treatment naïve population by gender, age group and injecting status using the published OCU estimates. The tables also include the NDTMS in treatment population figures as shown in chapter 7 by gender, age group and injecting status. Please be aware that although the majority of published OCU estimates have been taken from the most recently published data (2009/10), the gender estimates will be calculated using previously published data.

Table 3: Gender of treatment naïve population (using previously published estimates)

	OCU Estimate (%)	OCU Estimate (No.)	Local In Treatment Data (%)	Local In Treatment Data (No.)		Estimated Treatment Naïve Population	
						No.	%
Male	72.6	1615	71.5	925		519	32.1
Female	27.4	609	28.5	369		180	29.6

Table 4: Age of treatment naïve population (most recent published data: 2009/10)

	OCU Estimate (%)	OCU Estimate (No.)	Local In Treatment Data (%)	Local In Treatment Data (No.)		Estimated Treatment Naïve Population	
						No.	%
15 - 24	12.1	269	7.3	95		130	48.3
25 - 34	36.0	801	31.7	410		291	36.3
35 - 64	51.9	1154	60.4	781		278	24.1

The current DAAT Treatment Plan looks to improve treatment penetration for groups of OCUs under-represented in treatment. By April 2014, East Sussex is looking to engage more treatment naïve individuals aged 15 to 24 and 25 to 34 in treatment; the plan states that 70% of the treatment naïve population should fall with these two cohorts. However, data for 2012/13 shows that 84.6% of the treatment naïve population is aged 15 to 34. Based on local calculations, while the proportion of treatment naïve clients aged 15 to 24 has increased since the previous assessment (43.1%), those aged 25 to 34 has seen a slight reduction, which suggests that more treatment naïve clients within this cohort accessed structured treatment during 2012/13. However, more work still needs to be done to target these groups of individuals.

Table 5: Injecting status of treatment naïve population (most recent published data: 2009/10)

	OCU Estimate (%)	OCU Estimate (No.)	Local In Treatment Data (%)	Local In Treatment Data (No.)		Estimated Treatment Naïve Population	
						No.	%
Injectors	41.5	923	65.0	841		62	6.7
Non Injectors	58.5	1301	35.0	453		637	49

The plan also looks to increase the number of treatment naive non-injectors accessing treatment. However, the estimated 2012/13 treatment naïve population is broadly the same as the previous assessment (48.8%).

[7] This prevalence estimate includes a confidence interval of 2008 – 2606, meaning there is a 95% certainty that the true value exists within the range 2008 to 2606, though it is more likely to lie near the estimate itself

Hay's research goes on to provide estimates for those Opiate and Crack users within the county aged between 15 and 64. Opiate users and Crack users are not mutually exclusive. The document suggests that 54.2% (1205) of the total OCU population uses Crack, and our local data shows that 29.9% (387) of our in treatment population have declared use of Crack, demonstrating a stark difference.

Table 6: Problem substances of treatment naïve population (most recent published data: 2009/10)

	OCU Estimate (%)	OCU Estimate (No.)	Local In Treatment Data (%)	Local In Treatment Data (No.)
Opiate Users	95.8	2131	85.8	1110
Crack Users	54.2	1205	29.9	387

7. National Drug Treatment Monitoring System (NDTMS) Data

The following narrative will look at data taken from the Adult Treatment Case Management System (Nebula) and submitted to the NDTMS. It represents those who presented to treatment in the county, declaring a drug as their primary substance and were aged 18 or older on the 1st October 2012, and who were receiving a treatment intervention in the 12 months to March 2013. Unless stated otherwise, data shown will relate to the most recent treatment episode for each individual.

A total of 1294 clients were receiving at least one structured intervention from the Adult Drug Treatment Services between 1st April 2012 and 31st March 2013. This is an increase of 4.8% compared to last year, when there were 1235 clients in treatment.

7.1. Personal Profile

Much like previous years, the majority of the in-treatment population are male (71.5%), which is in line with the 2012/13 national findings from the NDTMS, where 73% of clients in treatment were male. There were 369 (28.5%) female clients in treatment. As a total of the 260 clients in the 18 to 29 age group, 38% were female, which is the highest representation of females in treatment compared to the other age groups.

Table 7: Numbers as % of male / female population: by age group

	Female		Male		Total			
Age Group	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Female %**	**Male %**
18 to 29	99	26.80%	161	17.40%	260	20.10%	38%	61.90%
30 to 44	183	49.60%	504	54.50%	687	53.10%	26.60%	73.40%
45 to 59	80	21.70%	234	25.30%	314	24.30%	25.50%	74.50%
60+	7	1.90%	26	2.80%	33	2.60%	21.20%	78.80%
Total	**369**	**28.5%**	**925**	**71.5%**	**1294**	**100%**		

The largest numbers of individuals fall into the 30 to 44 age bracket - 687 (53.1%). Almost half of all clients - 590 (45.6%) are aged over 40; an increase on the previous assessment when there were 491 clients aged over 40 (39.8%). This is also in line with national findings[8] which state that the over 40s are the only age group whose numbers are increasing. The research suggests that this group is a cause for concern and present a significant challenge for services. The treatment population is ageing.

[8] NTA Drug Treatment 2012: Progress made, challenges ahead: http://www.nta.nhs.uk/publications.aspx

Table 8: Ethnicity of in-treatment population by LA: April 2012 to March 2013

Local Authority	All White	All Mixed	Asian/ Asian British	Black/ Black British	Chinese or other Ethnic Group	Not Stated	Total	% of Total
Eastbourne	399	9	*	*	*	*	419	32.4%
Hastings	512	16	*	9	7	*	550	42.5%
Lewes	101	*	0	0	0	*	104	8.0%
Rother	129	0	0	0	0	*	130	10.0%
Wealden	87	0	0	0	*	*	90	7.0%
Other	0	*	0	0	0	0	*	0%
Total	**1228**	**27**	**5**	**13**	**11**	**10**	**1294**	

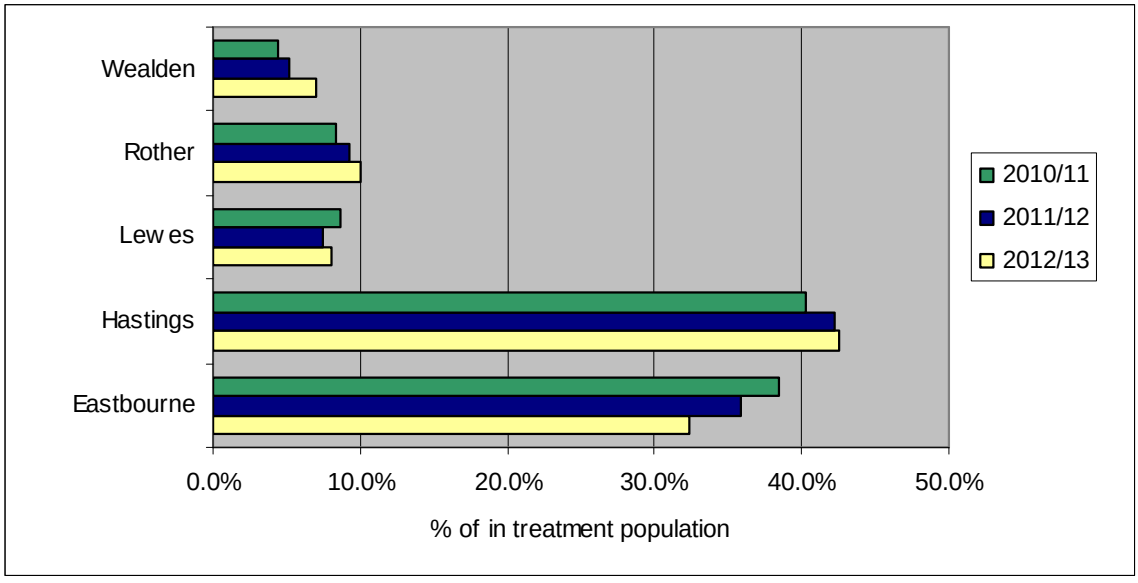
* **NB -** Figures which are 5 or less have been replaced with a * to help stop individual cases from being indentified

The in-treatment population also reflects the ethnic backgrounds of local people. We continue to have a small BME population in East Sussex, and this is also reflected within the drugs data, with minimal numbers of those giving their ethnicity as Mixed, Black / Black British, Asian / Asian British or Chinese or other Ethnic Group living in the county. The table below shows the ethnicity of the in-treatment population in the 12 months to March 2013, by local authority**.**

The Equality Impact Assessment (EIA) for the Drug and Alcohol Recovery Service identified the following groups who may be under-represented in treatment:

- **People who are lesbian or gay who use drugs**: 14 clients (1.1%) of the 2012/13 in-treatment population were recorded as homosexual. This is broadly the same as the previous assessment (1.6%)
- **Men who have sex with men and are taking drugs**: 6 clients (0.7%) of the 2012/13 in treatment population were recorded as homosexual and male. This is in line with 2011/12 findings.

Graph 1: In-treatment population by district of residence: 2011/12 and 2012/13



Much like previous years, it is also apparent that the largest numbers of individuals engaging with the services live in the urban areas of Hastings and Eastbourne; where the main drug treatment services are based. However, the numbers in Hastings continue to increase, although Eastbourne has seen a decline since 2010/11. There continues to be an increase in

numbers for those individuals accessing the services from the more rural areas of the County. Those clients living in Wealden and engaging with the treatment services have increased by 42.9% compared to 2011/12 from 63 to 90 and Lewes and Rother residents accessing treatment have increased year on year by 13% respectively, from 92 to 104 in Lewes and from 115 to 130 in Rother.

Recommendation:
4. Ensure that LGBT data is collected and analysed in order to target appropriate engagement activities
5. Increase the take up of DARS in rural areas by 25%

Also of note within the group of 1294:

- 1128 (87.2%) listed opiates and / or crack as a problem substance and can be categorised as an OCU. The proportion of OCUs has not changed since the previous assessment, although national research[9] suggests that fewer heroin or crack addicts are coming in to treatment.
- 124 (9.6%) clients stated that they were receiving treatment from mental health services for reasons other than substance misuse, and can therefore by categorised as dual diagnosis.
- Although 231 (17.9%) of the individuals have either all or some of their children living with them, 531 (41.02%) have children who live elsewhere including with a partner or other family members. This is an increase on the findings from last year, when 419 (33.9%) had children that lived elsewhere. However, in 2011/12, there were 577 clients (46.6%) who were recorded as not a parent/ no children compared to 516 (39.9%) in 2012/13.

7.2. Referral Source

When looking at their most recent episode, the majority of clients (58%) self-referred into treatment. This is higher than the national average of 42%. GPs made up a further 7.6% of referrals. Low numbers of referrals from sources such as A&E, hospital, psychiatry services, outreach, or even through a relative are also evident, with this group making up 2% of the total. However, a similar referral pattern for all sources outlined above has been evident in previous needs assessments, and historically, has been due to incorrect recording at the point of assessment by the treatment services.

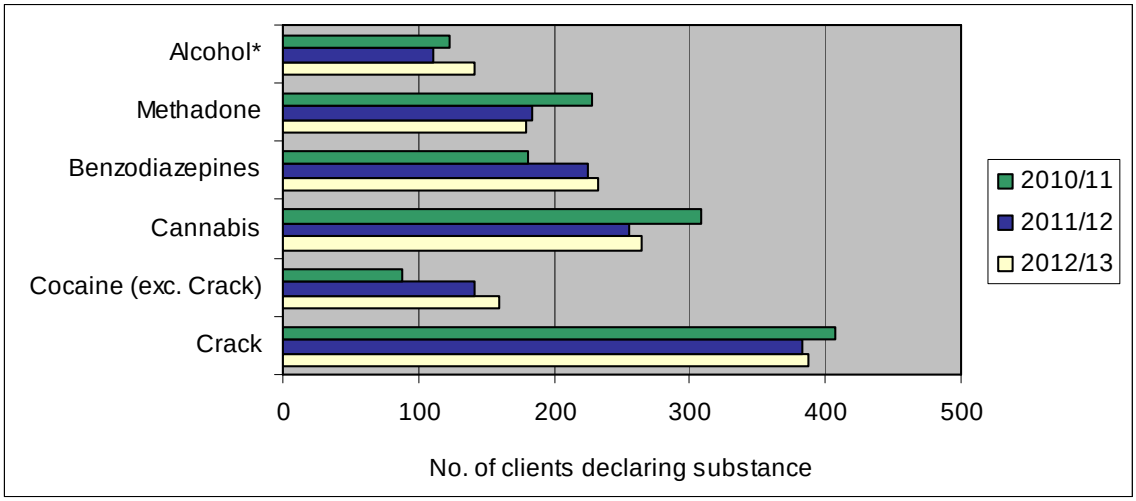
A total of 267 (20.6%) clients were referred into treatment via a Criminal Justice route such as Prison / CARAT (Counselling, Assessment, Referral, Advice and Through-care), Probation, Arrest Referral / Drug Intervention Programme (DIP), or via a Drug Rehabilitation Requirement (DRR). This is similar findings to the previous assessment (19.9%), although less than the national findings of 28%. These will be looked at in more detail later in the document.

7.3. Substance Misuse

Local data shows that the majority of people using the service are OCUs, declaring opiates or crack as their main drug. There were 995 (76.9%) clients declaring heroin as their primary substance, with a further 22 listing it as a secondary or tertiary substance. Although these figures are a slight reduction on 2011/12 findings when 77.2% of the in-treatment population declared heroin as their main drug, this is in line with the national picture.

[9] NTA Drug Treatment 2012: Progress made, challenges ahead: http://www.nta.nhs.uk/publications.aspx p6

Graph 2: Clients declaring drug as primary, secondary or tertiary substance (other than heroin): 2010/11, 2011/12 and 2012/13



*Alcohol declared as a secondary or tertiary substance

The next most prevalent main drug declared was cocaine (excluding crack) and the number of individuals declaring this as one of their problem substances has increased by 17 (+12.0%) since the previous year and an increase of 71 (+80.7%) since 2010/11. The proportion of the in-treatment population declaring cocaine as a problem drug has increased from 7.5% in 2010/11 to 11.5% in 2011/12 and to 12.3% in 2012/13. Introducing 'Test on Arrest' has identified a cocaine using cohort, as well as the opiate using cohort that it was originally set up to identify.

The number of clients declaring benzodiazepines as a problem substance has increased by 52 (+28.7%) since 2010/11, whilst methadone has seen a decline of 21.5%. Those declaring crack and cannabis as a problem substance are similar to findings in 2011/12, while declared usage of alcohol as a secondary or tertiary problem drug has seen an increase of 31 (+27.9%).

Opiate only users in treatment had an average age of 40, while those adults in treatment for cocaine (excluding crack) had a much lower average age of 29. The average age for those in treatment for cannabis use was 30.

Also of note is that the Treatment Plan 2013/14 includes a measure around improving the recording of alcohol as a secondary substance. A baseline was set at 111 using 2011/12 in-treatment data. The 2012/13 in-treatment data showed a total of 142 clients declaring alcohol as a secondary substance; an increase of 31 (+27.9%) on the baseline.

Recommendation:
6. Implement a training programme to address the risk of accidental overdose
7. Review recording of 'alcohol as a secondary substance' to assess any emerging trends

7.4. Interventions

When a client is referred into treatment and subsequently has their needs assessed by a key worker, this marks the beginning of their treatment episode. Each episode can contain a number of modalities or treatment interventions, which the client can finish in either a planned or unplanned way, or have the intervention withdrawn. Once they have completed their treatment, or have dropped out or been transferred elsewhere, the treatment episode ends and the client is discharged, with the discharge reason reflecting the reason why the client's episode of structured treatment ended.

Please note; the implementation of 'Core Dataset J' (CDS J) by the PHE on 1st November 2012 has condensed the post assessment options down to two structured modalities: pharmacological (prescribing) and psychosocial. One result of the change in the method of recording interventions is that new modalities were opened and closed, despite being in continuous treatment. These 'replacement' modalities could appear falsely as subsequent interventions with associated waits; therefore, the recording of interventions is not comparable to last year.

7.5. Employment and Housing

Employment and housing remain crucial aspects in helping individuals sustain substance free lifestyles once they have been discharged from treatment. It continues to be recommended that partnerships adopt an integrated approach to tackling these issues; assessing the level of employment and housing need in order to provide a service that supports this.

7.5.1. Employment and Housing: Local NDTMS data

Of those 1294 clients in treatment, 70 (5.4%) presented to treatment with no fixed abode and were subsequently categorised as having an urgent housing problem. A further 119 (9.2%) stated they had a housing problem. This is slightly higher than the previous assessment (4.5% and 8.1% respectively). Almost a quarter (23.5%) of clients in the 18 to 29 age group had a housing need.

There were also 229 (17.7%) clients who stated they were unemployed while a further 385 (31.4%) reported they were unemployed and seeking work. The age group with the highest amount of employment need (57.6%) was the 60+. 197 clients (15.2%) stated that they were in regular employment, which are similar findings to the previous assessment.

Those clients stating they are long term sick or disabled is also seeing a year on year increase with 18.4% of clients declaring this in 2012/13 compared to 15.6% in 2011/12 and 10.3% in 2010/11. 9 out of 10 clients in this group can be categorised as an OCU, with 80.3% declaring Heroin as a primary substance. In comparison, 60.8% of clients in the regular employment cohort listed Heroin as a main drug, with a further 22.7% listing Cocaine (excluding Crack).

Table 9: Age and gender of those with a housing or employment need: 2012/13

	18 to 29				30 to 44				45 to 59				60+				Total			
	F	M	Total	%	F	M	Total	%	F	M	Total	%	F	M	Total	%	F	M	Total	%
Accommodation Need	21	40	61	23.5%	14	90	104	15.1%	2	22	24	7.6%	0	0	0	0.0%	37	152	189	14.6%
Employment Need*	47	81	128	49.2%	91	260	351	51.1%	36	101	137	43.6%	3	16	19	57.6%	177	458	635	49.1%
Total	**68**	**121**	**189**	**72.7%**	**105**	**350**	**455**	**66.2%**	**38**	**123**	**161**	**51.3%**	**3**	**16**	**19**	**57.6%**	**214**	**610**	**824**	**100.0%**

*Unemployed / Unemployed and seeking work

NB: there were also 19 individuals aged 60+ with an identified employment need. No individuals aged 60+ had an identified housing need

The proportion of clients declaring both an accommodation and an employment need remains the same as the previous assessment at 7%.

Recommendation:
8. Assess the impact of Welfare Benefit Reform with similar cluster areas

8. Discharges from Treatment

Data from the PHE shows that at 2012/13 year end, 65% of adults in East Sussex completed their treatment journey and left in a planned way. This is a slight increase on the previous year (62%). This planned discharge rate remains higher than the national figure (47%).

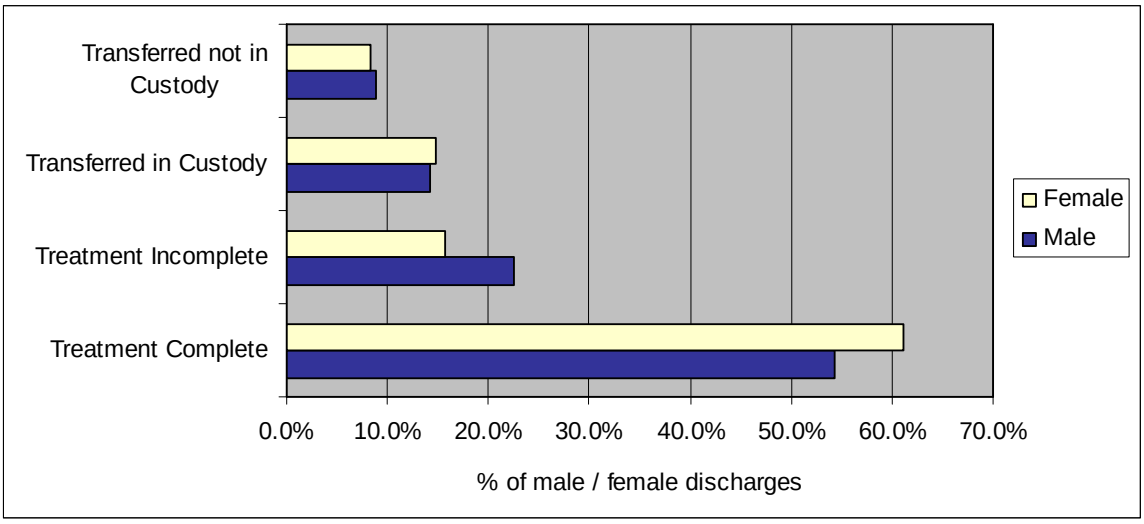
Local data shows that there were 474 discharges from treatment during 2012/13, which relates to 458 clients as 16 individuals were discharged more than once during the 12 month period. Of this group of 16, six came back into treatment within 6 months of completing their previous treatment journey in a planned way.

Of the 458 clients discharged 350 (76.4%) were male and 202 (50.4%) were aged 30 to 44. This is in line with the East Sussex in-treatment population. Also of note when looking at discharge reasons as a proportion of the total number of male or female discharges, is that females are more likely to leave treatment in a planned way.

Of the 458 client discharges:

- 256 (55.9%) completed treatment
- 66 (14.4%) were transferred in custody
- 96 (21.0%) did not complete treatment
- 40 (8.7%) were transferred not in custody
- The percentage of clients who did not complete treatment (21.0%) has increased from the previous year (15.4%).

Graph 3: Discharge reason by gender: 2012/13



8.1. Primary Drug and Discharge Reason

262 clients leaving treatment declared heroin as their main drug, of which 85 (32.4%) left treatment in a planned way. In 2011/ 2012, 41.3% of clients with heroin as their primary drug left treatment in a planned way. A further 22.5% were transferred in custody; the highest rate of all declared substances.

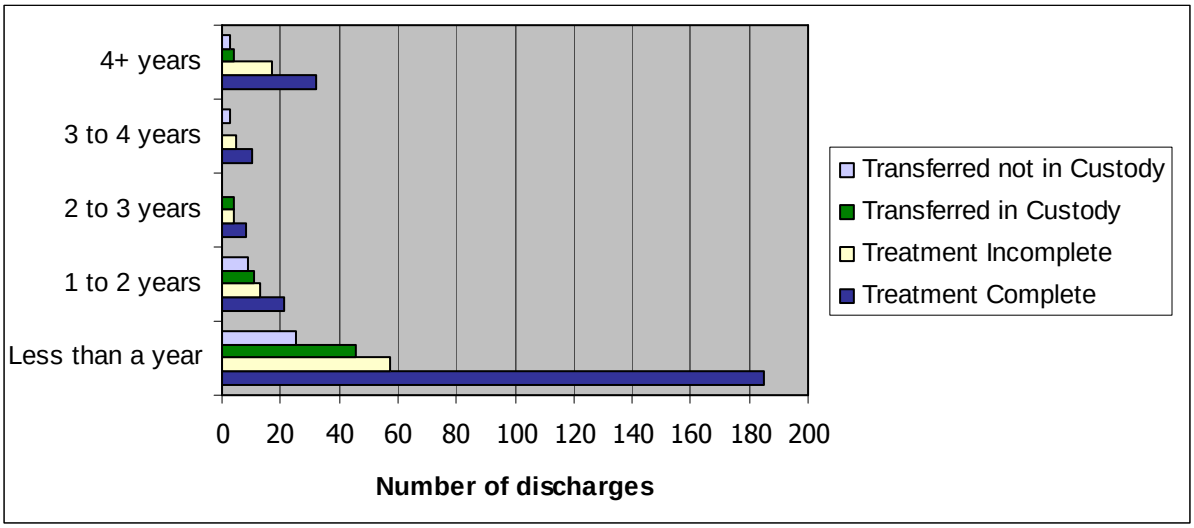
Of the non-opiate client group, the largest numbers of discharges relate to those declaring use of cocaine or cannabis as their main drug. 9 out of 10 clients declaring cocaine as their primary substance and 8 out of 10 individuals citing cannabis, left treatment with a positive outcome. The 'Test on Arrest initiative has brought more Criminal Justice clients using powder cocaine into treatment. A number of other factors may also contribute to the positive outcomes for non-opiate users such as shorter duration of use and more recovery capital, in terms of employment, housing and supportive social networks. Evening clinics enable clients to maintain employment and sustain treatment.

Also of note is that while the majority (50.4%) of discharges fall into the 30 to 44 cohort, which is a reflection of the in-treatment picture, almost two thirds (64.0%) of those clients who were discharged and declared cocaine as their main substance were aged 18 to 29.

8.2. Duration of Treatment

Over two thirds (68.3%) of discharges during the 12 month period were for clients who were in treatment less than a year. Of those 313 discharges, 185 (56.6%) were positive, while there was a broadly even split between those who did not complete their treatment journey (18.2%) and those who were transferred in custody (14.7%).

Graph 4: Duration of time in-treatment by discharge group: 2012/13



A further 15.3% spent between 1 and 3 years in treatment and 4.1% between 3 and 4 years. Within both of these groups, the majority of clients left treatment in a planned and agreed way. Also of note is that 56 (12.2%) of clients were in treatment for more than 4 years, which is higher than findings from 2011/2012 (9.4%) and 5% in 2010/11. All clients within this group can be categorised as OCUs. This group included 6 individuals who had been in treatment for more than 10 years; 2 completed their treatment journey, 1 was transferred in custody and 3 did not complete treatment.

8.3. Aftercare

A pivotal element in assisting clients to manage lifestyle following treatment is the aftercare provision at the drug treatment services. Currently, clients are offered prevention work, avoiding triggers, advice and information on increased overdose risk, sign-posting to other community services, referral to employment, education, training, housing, peer mentor scheme and any other interventions identified as appropriate for the individual. People are also given the opportunity to be seen in alternative locations in order to avoid contact with other service users at the main base.

Also of note in East Sussex:

- SMART Recovery groups
- Narcotics Anonymous delivering weekly meeting in Hastings
- A fortnightly detox support group for those contemplating detox, undergoing detox or those who have completed detox

9. Recovery Diagnostic Toolkit (RDT)

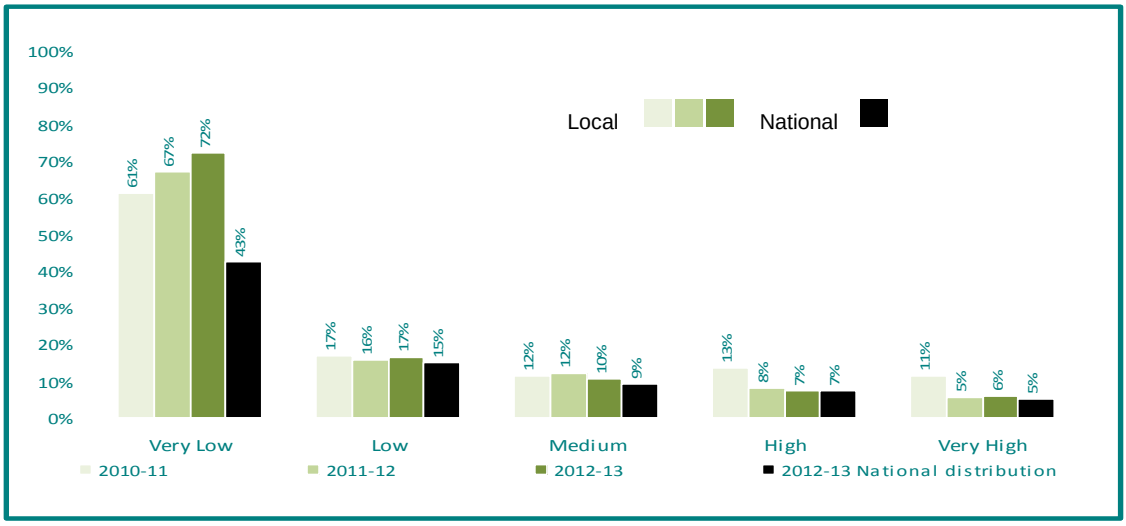
The Public Health England Recovery Diagnostic Toolkit (RDT)[10] provides analysis on different groups of clients, including opiate and non-opiate, treatment naïve clients, the more complex clients and those clients that have been in treatment for 4 or more years. As well as an overview of successful completions and non-re-presentations, it breaks down local treatment data into themed sections about factors linked to outcomes.

With regard to those entering treatment, it is vital to understand what plans are in place for the relatively high levels of complexity in those presenting with particularly high rates of:

- opiate or crack use
- daily use of amphetamines, cannabis, cocaine or crack
- injecting
- hazardous drinking
- housing problem
- referral from criminal justice
- previous unplanned episodes

The above characteristics will significantly affect their chances of successfully completing. In East Sussex in 2012/13, those clients in the very low complexity group were twelve times more likely to achieve a successful completion than those in the very high group. There is a risk that the PbR approach might skew incentives towards working with less complex cases.

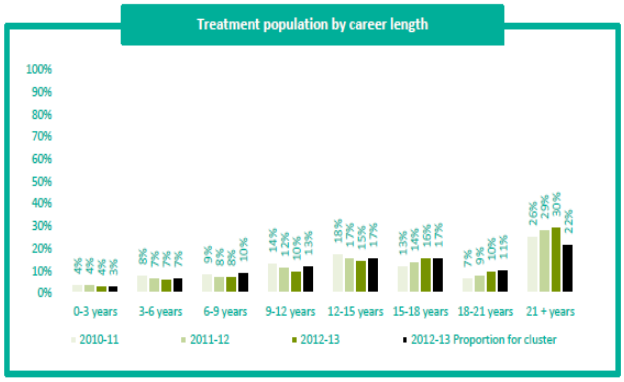
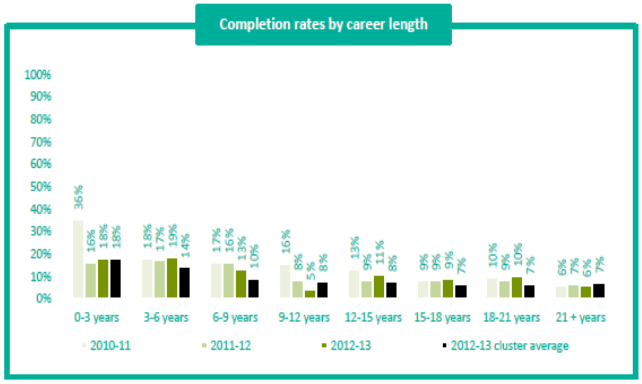
Graph 5: Completions by complexity group



Out of the 298 treatment naive presentations citing each complexity indicator in 2012/13, 51 clients (33%) were attributed to by criminal justice referrals (33%) and 39 clients (25%) had a housing problem/ no fixed abode. There were 798 clients who had previously presented to treatment. Of this cohort, 97 (37%) had a housing problem/ no fixed abode and 90 clients (34%) cited a daily opiate usage.

The RDT report provides insight into those who have been in treatment a long time, and arguably stuck. The data below shows that the proportion of opiate users who have had drug using careers for 21 years or more has gone up from 26% in 2010-11 to 30% in 2012-13, while the proportion who have been using for 15 years or under has fallen or remained the same year on year. This is in line with national trends, which suggest that on a more sustainable recovery, which has tried to be reflected in the complexity model built into the DARS from April 2014. However, this is still relatively untested and should be kept under review.

[10] NTA Recovery Diagnostic Toolkit 2012/13 – October 2013 – Public Health England

Graph 6: Treatment population by career length	Graph 7: Completion rates by career length
	

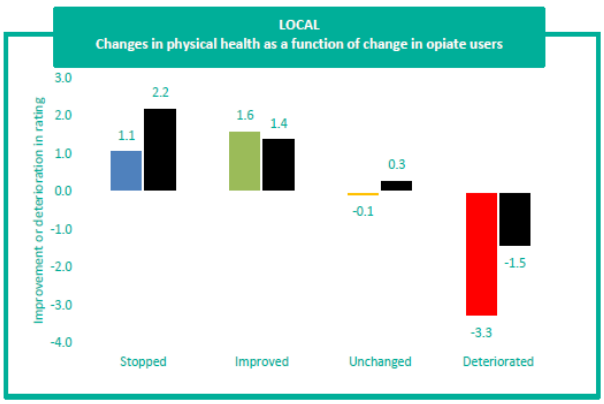
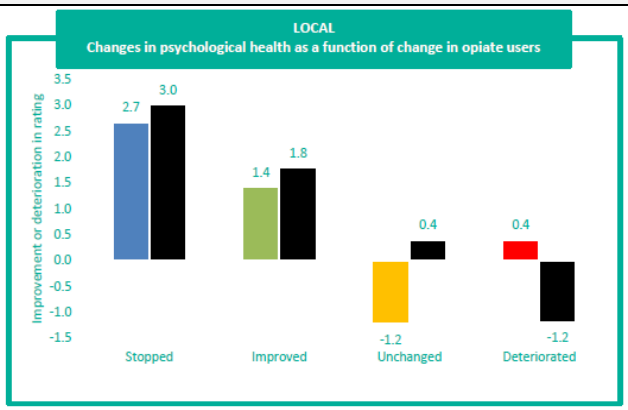
Opiate clients with shorter drug-taking careers (0 to 6 years) tend to have a greater chance of completing their treatment successfully than those who have been using longer, as the graph above shows. Interestingly, in 2012/13, those clients with a career length of 9 to12 years had the lowest successful completion rates than any other career length.

20% of clients (219) have had 4 or more previous treatment journeys and 16% (168) have had 4 or more previous treatment journeys ending in unplanned exit. Both of which are an increase on the last 2 years.

Recommendation:

9. Ensure that all reviews of the DARS consider to the impact of PbR incentives.
10. Ensure the clinical audit programme assesses the effectiveness of working with more complex clients
11. Ensure the clinical audit programme picks up active key working, access to psychosocial interventions and links to mutual aid.
12. Extend the range of aftercare, ensuring a wide range of activities and mutual aid are available for people completing treatment

In the first six months of treatment, changes to the level of opiate use will significantly affect a client's health and wellbeing. The graphs above show the changes in physical and psychological health of opiate users after six months in treatment. Locally, clients who stopped using opiates improved their physical health score by 1.1 on average and their psychological health score by 2.7.

Graph 8 : Changes in physical health as a function of change in opiate user	Graph 9 : Changes in psychological health as a function of change in opiate users
	

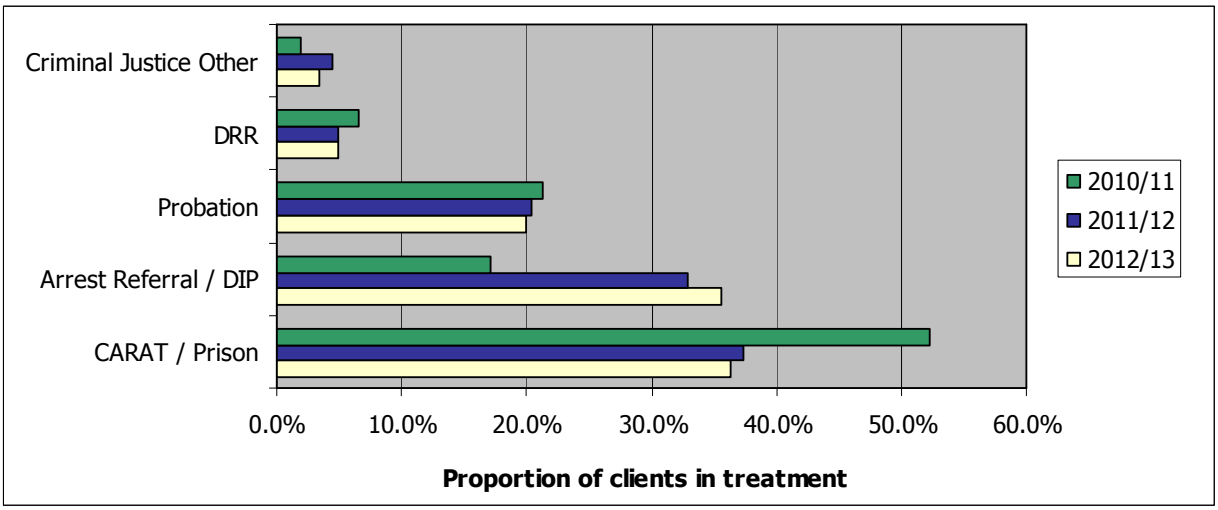
NB: A value above zero indicates there has been an increase in the health of clients in that category, whereas a value below zero indicates the health of clients in that category has fallen. In each instance, the black column relates to national data.

Those clients who improved (the number of days of Opiate use went down by 13 days or more) saw an improvement in their physical health by 1.6 on average and an improvement in their psychological health rating by 1.4 on average. When compared to the 2011/12 assessment, clients who reduced their Opiate usage (Improved) only saw an improvement of 0.4 in their physical health rating and 0.3 in their psychological health.

10. Criminal Justice Clients

Of those 1294 clients in treatment in the 12 months to March 2013, 267 (20.6%) were referred into their most recent treatment episode via a criminal justice route, which is comparable to last year's findings (19.9%). There has been a noticeable shift in referral routes over the last three years. The proportion of clients referred into treatment through the prisons has reduced, while those referred into structured treatment via the Arrest Referral route has increased. This is understood to be largely driven by the Test on Arrest initiative that went live in Hastings and Rother on the 1st April 2011 and rolled out across the rest of the County from April 2013.

Graph 10: CJ Referral route for in-treatment population: 2010/11, 2011/12 and 2012/13



10.1. Personal Profile

A fifth of clients in this cohort were female (20.2%), and only 12.4% were aged 45+; 54.3% on this in-treatment population were in the 30 to 44 age bracket. Also of note is that half (51.7%) of those clients in contact with the criminal justice services are resident in Hastings, with a further 84 (31.5%) living in Eastbourne.

Other areas of note within the group of 267 are:

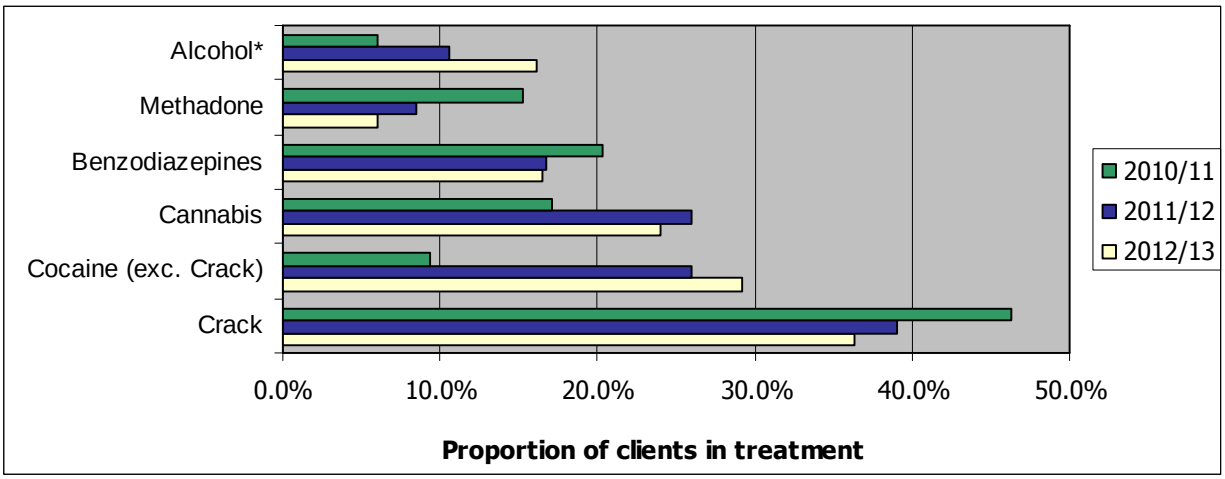
- A higher percentage of clients stated that they had a housing problem; 23.6% in 2012/13 compared to 20.7% in 2011/12 and 16.2% in 2010/11
- There continues to be a drop in those Criminal Justice clients stating that they are unemployed; 11.6% in 2012/13 compared to 16.3% in 2011/12 and 28.7% in 2010/11.
- 37.1% said that they were not a parent (81.8% male); while a further 44.9% stated that they had children but that they were living elsewhere (82.9% male), which was an increase on previous findings.
- At the point of assessment, 8.6% explained they had children living with them; slightly less than 9.8% in the 2011/12 findings

10.2. Substance Misuse and Interventions

The majority of clients (71.5%) can be categorised as OCUs, with two thirds (66.7%) listing heroin as their primary substance; lower than the in-treatment picture. Cocaine continues to overtake crack as the second most prevalent drug for this cohort as a quarter 69 (25.8%) of clients listed cocaine as their main drug compared to 51 (20.7%) in 2011/2012 and 13 (6%) in 2010/11. This is also significantly higher than the in-treatment picture where only 9.6% of clients listed it as a main substance, which suggests that Criminal Justice clients are more likely to use cocaine than the rest of the in-treatment population.

Other substances listed as a first, second or third drug are shown in the table below against the proportion of clients who declared the substances in 2011/12 and 2010/11.

Graph 11: Primary, secondary or tertiary substance declared by CJ in-treatment population (other than heroin): 2010/11, 2011/12 and 2012/13



* Alcohol declared as a secondary or tertiary substance

Over the last three years the proportion of people reporting cocaine use has increased to 29.2%. New services and interventions have been introduced to respond to this need including a 'short duration court order', part of a Specified Activity Requirement (SAR), which was developed through the Surrey and Sussex Probation Trust (SSPT). The percentage of those Criminal Justice clients declaring use of cannabis has seen a slight reduction since the previous assessment; 24% in 2012/13 compared to 26% in 2011/12 and 17.1% in 2010/11.

There has been a continuous rise in those clients declaring Alcohol as a secondary or tertiary substance (16.1% of clients compared to 10.6% in 2011/12 and 6% in 2010/11).

10.3. Drug Intervention Programme (DIP) Quarterly Summary Report

The PHE publish a DIP Quarterly Summary Report that contains key treatment outcome and diagnostic data at a partnership level to assist local areas to monitor performance and compare that to national trends with regard to clients referred into structured treatment via criminal justice agencies.

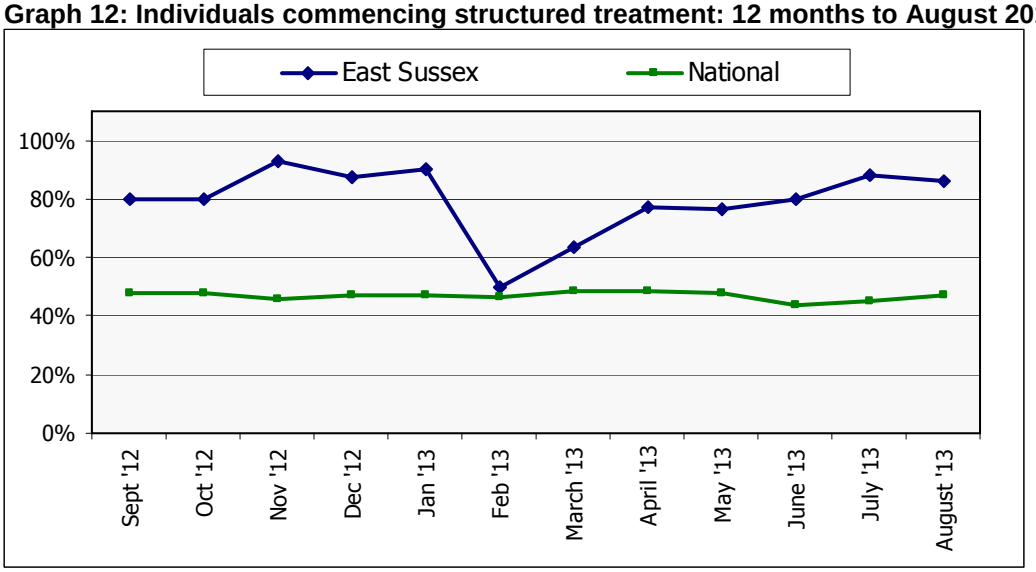
The 2012/13 Q4 report shows that 82% of clients were triaged within 6 weeks of a DIP referral and started a structured intervention. This is higher than the national figure of 64%, and places East Sussex in the Top Quartile across all DAATs in the Country.

This report also shows that in the 12 months to April 2013, 28% of all DIP clients in treatment successfully completed treatment. This is also higher than the figure for England as a whole (14%). Of note is that 31 clients (6%) who successfully completed treatment between April and September 2012, re-presented within 6 months of their discharge; 2 Opiate users and 29

non Opiate users. However, this too is significantly below the re-presentation rate for England which is 14%.

The most current data shows the numbers of individuals being referred to and then starting structured drug treatment through the Drug Intervention Programme remains largely consistent, with East Sussex performing better than the national picture in relation to this indicator since September 2011.

Graph 12: Individuals commencing structured treatment: 12 months to August 2013



11. Injecting Drug Users (IDUs) and Blood Borne Virus (BBV) Data

During 2012, as part of the national unlinked anonymous monitoring programme, the Health Protection Agency undertook an anonymous survey of people who were in treatment in Hastings and Rother Community Substance Misuse Team who inject drugs. Samples were tested for antibodies to HIV, Hepatitis B and Hepatitis C and the following was noted:

- 59% of the dried spot tests were positive for Hepatitis C antibodies (similar to previous assessments)
- 84% have had a blood test for HIV
- 84% have had a blood test for hepatitis C and of those that were positive a third were not aware of their status
- 8 out of 10 respondents stated they have been vaccinated against Hepatitis B
- 1 in 9 injectors reported sharing needles or syringes, while 1 in 4 reported sharing spoons and 1 in 5 reported sharing filters
- Of those who stated they had sex in the 12 months preceding the questionnaire, the majority (46%) said they never use a condom. This is a higher proportion than the previous questionnaire when 39% explained they never use a condom

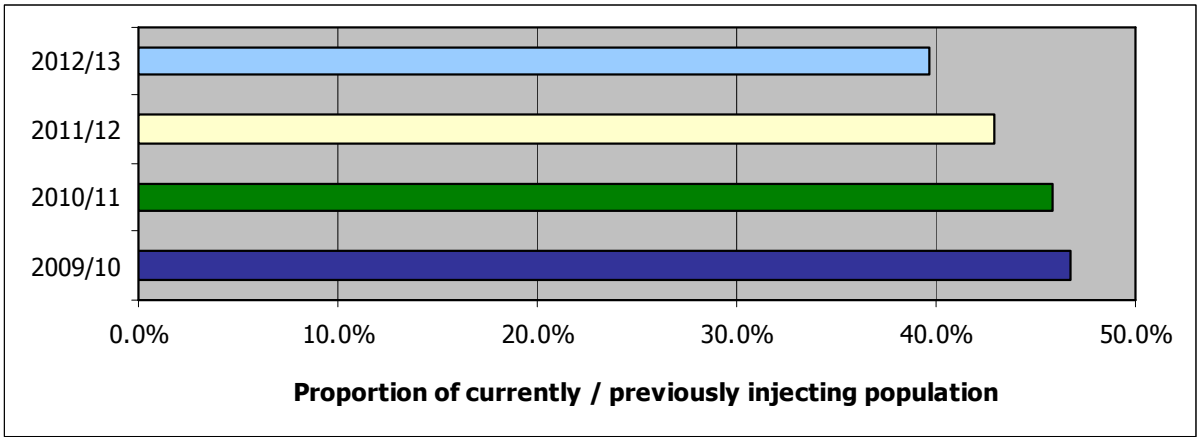
Recommendation:
13. Investigate ways to further promote safer injecting, reducing sharing and safer sexual behaviour

11.1. Local Data

Of the 1294 clients in treatment in 2012/13, 812 (65%) stated that they were currently or previously injecting, which is in line with findings from the previous assessment. 41% of clients declaring heroin as their main drug also stated that they were currently injecting, which is in line with previous findings (41.1%).

Of the 841 clients who stated that they were previously or currently injecting, 334 (39.7%) had shared injecting equipment. This is a further reduction when compared to previous assessments; 42.9% of previously or currently injecting clients explained that shared equipment in 2011/12, 45.8% in 2010/11 and 46.7% in 2009/10.

Graph 13: % of currently / previously injecting clients who share equipment

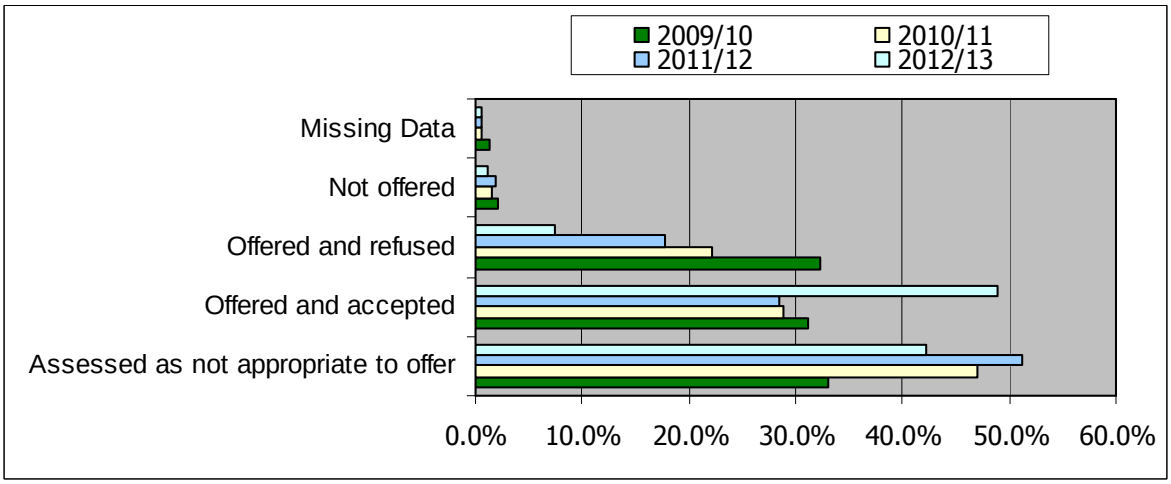


11.2. Hepatitis C

Around 90% of hepatitis C infection is thought to be caused by using injecting equipment. NICE published Public Health guidance[11] outlines those groups at increased risk of Hepatitis C compared with the with general UK population. These include:

- People who have ever injected drugs
- Babies born to mothers infected with Hepatitis C
- Prisoners including young offenders
- Looked-after children and young people, including those living in care homes
- People living in hostels for the homeless or sleeping on the streets

Graph 14: Hep C intervention status of those in treatment: 2009/10, 2010/11, 2011/12 and 2012/13



Local data shows a total of 633 (48.9%) clients in treatment in 2012/13 were offered and accepted a Hepatitis C test which is significantly more than 2011/12 when 352 (28.5%) of clients were offered and accepted a Hepatitis C test. Those who were offered but refused continues to see a reduction on previous findings, while less than 2% of clients were not

[11] NICE: Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection p9

offered a test at the point of assessment. However, of note is that those clients assessed as 'not appropriate to offer' has now fallen for the first time since 2008/09 from 33.1% in 2009/10, 47% in 2010/11, 51.3% in 2011/12 and 42.3% in 2012/13.

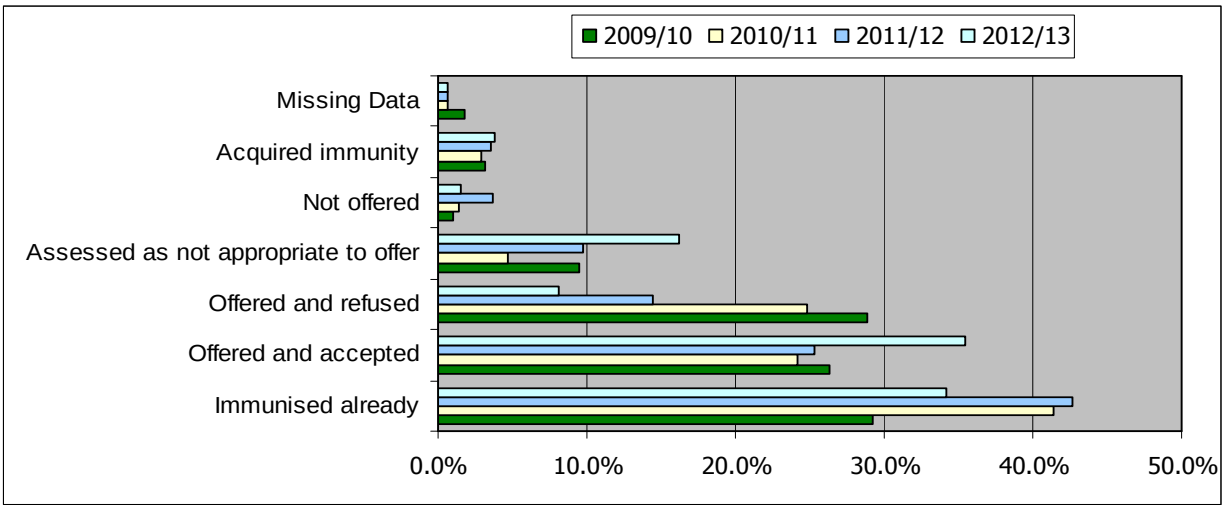
There were also 1286 responses to the questions about being Hepatitis C positive, with 261 (20.3%) clients stating that they had tested positive; broadly similar to 2010/11 findings. Over half (58%) of this group stated that they were currently injecting while a further 100 (38.3%) said they had previously injected.

11.3. Hepatitis B

A vaccination is available to prevent the transmission of hepatitis B. The guidance[12] also outlines those groups at increased risk of Hepatitis B and includes:

- Babies born to mothers infected with Hepatitis B
- People who have ever injected drugs
- Anyone who has unprotected sex
- Prisoners, including young offenders
- Looked-after children and young people, including those living in care homes

Graph 15: Hep B Vaccination status of those in treatment: 2009/10, 2010/11, 2011/12 and 2012/13



Those clients reporting that they are already immunised has decreased; 443 (34.2%) in 2012/13, 527 (42.7%) in 2011/12, 521 (41.4%) in 2010/11 and 407 (29.3%) in 2009/10. There has, however, been an increase in those clients which have acquired immunity and those that have offered and refused.

A total of 460 (35.5%) clients in treatment in the analysed 12 month period were offered and accepted a Hepatitis B vaccination, which is an increase on findings from the previous assessment (25.3%).

The proportion of clients assessed as not appropriate to offer has increased to 209 clients (16.2%). This is up on findings from the previous assessment (9.7%), and was 4.7% in 2010/11.

The vaccination requires three doses of the vaccine at specified intervals. At least one dose provides some protection. Table 10 reports the percentage of people who have accepted a vaccination against hepatitis B, detailing those who had had one, two or three doses.

[12] NICE: Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection p9

Table 10: Hep B vaccination status: 2012/13

	Total	%
No. of individuals who were offered a vaccination	564	43.6%
No. of individuals who accepted a vaccination	460	81.6%
One vaccination	36	7.8%
Two vaccinations	27	5.9%
Three vaccinations	71	15.4%
Course completed	296	64.3%
No information recorded	30	6.5%

A total of 430 clients (93.5%) who accepted a Hepatitis B vaccination had received at least one vaccination by the end of the reporting period. This is an increase on the previous assessment (87.9%). Although this highlights good levels of communication between key workers and those who record the information in Nebula, more work still needs to be undertaken as there were 30 clients (6.5%) who accepted a vaccination, but for which no Hepatitis vaccination information is recorded.

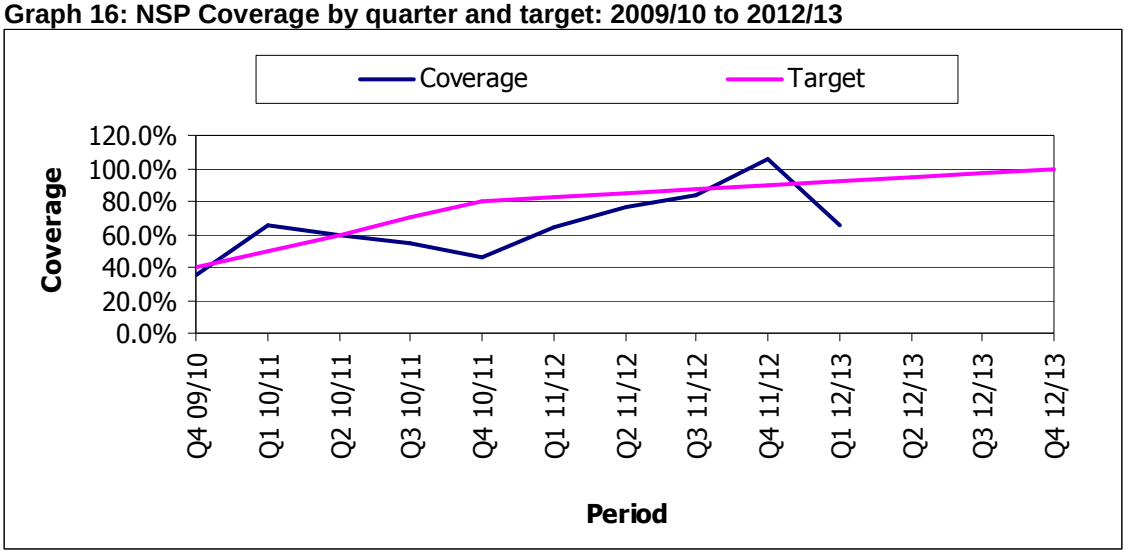
Recommendations:

14. Benchmark BBV against other areas for clients assessed as 'not appropriate to offer'.
15. Ensure the clinical audit programme includes activities to reduce BBV
16. Work across the region to pick up best practice in increasing the take up of the full course of hepatitis B vaccinations

12. Needle and Syringe Programmes (NSPs)

The needle and syringe programmes in East Sussex are provided by both the drug treatment services and a number of pharmacies across the county. These services offer a range of injecting equipment and disposal services and cover a variety of locations and times of day.

Graph 16: NSP Coverage by quarter and target: 2009/10 to 2012/13



Coverage in the county has been on an upwards trajectory since Q4 2010/11, with coverage beginning to exceed the target from Q3 2011/12. However, the higher coverage % in the later quarters of 2011/12 could be seen as an unusual peak in distribution.

Table 11: Coverage calculation by quarter: 2011/12 and Q1 2012/13

	2011/12				2012/13
	Q1	Q2	Q3	Q4	Q1
IDU Estimate	923	923	923	923	923
IDU in treatment	706	746	805	841	706
IDU not in treatment	217	177	118	82	217
Total equipment distributed	62,674	67,868	64,069	72,231	63,933
Number of IDU in regular contact	477	423	412	340	190
Average number of syringes supplied to each service user	131	160	155	212	337
Coverage - NICE calculation	**63.8%**	**75.8%**	**83.7%**	**105.1%**	**65.1%**
Coverage - Qtr syringes supplied to IDU not in treatment	289	383	543	881	295
Coverage - proportion of IDU in regular contact with NSP	51.7%	45.8%	44.7%	36.8%	20.6%

If you look at the volume of injecting equipment distributed, the volume in Q1 2012/13 is higher than Q1 2011/12. Although suggestions as to why this might be have been are offered below, it is clear that we need to know more about the population using the needle and syringe programme to have a greater understanding of the fluctuations in data.

One explanation could be that rather than increasing coverage, the scheme did increase distribution in 2011/12 but did so whilst increasing waste. The pharmacy based NSP distributes pre-packed items and the pack size was changed during the year (was increased then reduced following concerns about sharps waste).

Another explanation that has been proposed for seasonal variability in distribution is the high proportion of performance and image enhancing drug users who use the needle and syringe programme. Many of these users will use for a couple of six (or so) week cycles, and then not for the rest of the year. That pattern of use is probably more likely during Q2/Q3 of the year.

12.1. Supervised Administration

During 2012/13, there were 945 supervised doses/ consumptions in East Sussex, which is a reduction of 8.7% compared to 2011/12. The data shows that a total of 58 pharmacies have provided the service in the analysed 12 month period. This data shows that only 3 out of 10 individuals accessing the pharmacies for this purpose are female, and 27.9% were aged under 30, which is an increase of 81 on 2011/12.

Around 30% of the supervised administrations in Eastbourne took place at a single pharmacy, something that was similar in Hastings. Whilst this might present some issues in terms of coverage and availability, having two services that would appear to have a degree of expertise and an established relationship with service users does present opportunities for stronger partnership working.

Recommendation:
17. Investigate any opportunities to develop closer working with community pharmacists who are more engaged in the NSP and supervised administration.

13. Drug Related Deaths: Confidential Inquiry 2013

The table below shows the number of drug related deaths included in the local DRD inquiries by year of death, as well as the number of deaths per 100,000 East Sussex population reported to the national programme on Substance Abuse Deaths (np-SAD)[13].

Table 12: Drug related deaths in East Sussex: 2005 to 2013

	CONFIDENTIAL INQUIRY		np-SAD DATA	
Year	Number	Rate per 100,000 aged 16+	Number	Rate per 100,000 aged 16+
2005	12	2.95	23	5.66
2006	17	4.18	20	4.92
2007	17	4.08	17	4.08
2008	7	1.68	9	2.16
2009	21	4.98	26	6.17
2010	17	4.01	25	5.89
2011[14]	12	2.75	16	3.67
2012	5	1.14	-	-
2013	1	0.23	-	-

Personal data about drug related deaths received from the Coroner's Office since October 2012 has been reviewed to consider whether there are any indications of opportunities for earlier intervention. However, there is nothing to suggest there might have been. The review concludes that there is no additional information to inform a confidential inquiry. Also of note is that three files were unavailable to research. These files pertain to two deaths that occurred in 2010 and a death that occurred in 2012.

Recommendations Agreed by the DAAT Board:

18. Produce an annual np-SAD review.
19. Embed Serious Incident reviews into Treatment Performance Group to ensure that lessons are learnt and influence best working practice.
20. Review the care pathway from emergency care to drug and alcohol recovery services.

ADULT ALCOHOL TREATMENT

14. East Sussex Alcohol Strategy 2014 to 2019[15]

The five year alcohol strategy will seek to provide a framework for all stakeholders to work together to deliver effective prevention and intervention of alcohol harm, enhanced specialist treatment services and improved control and management of alcohol. Moreover it aspires to change the culture around alcohol through influencing people's attitudes, knowledge, skills and behaviours towards alcohol.

An action plan to implement and deliver the Alcohol Strategy has been developed around the three priority areas:

- develop individual and collective knowledge, skills and attitudes towards alcohol
- provide early help, interventions and support for people affected by harmful drinking
- create better and safer socialising

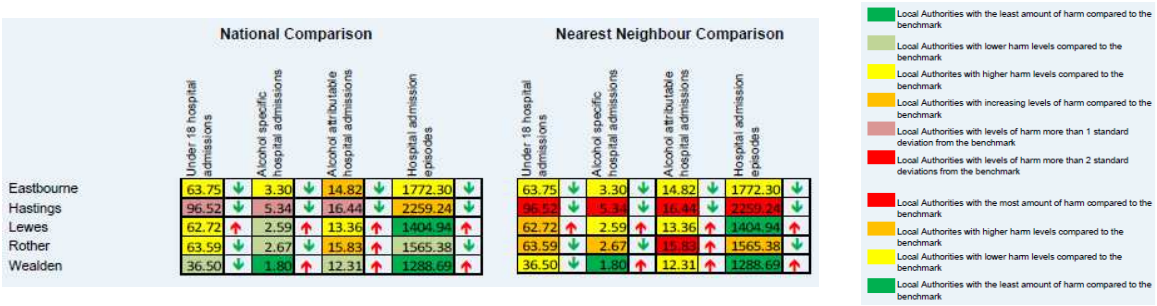
[13] Please note that these figures are subject to change due to a lag with Coroner's Inquiries and subsequent reports.
[14] Data from 2011 onwards is based on the revised census population
[15] When published, the complete strategy and action plan can be obtained from Anita McGrath (ESCC)

This plan is aligned with the annual DAAT Treatment Plan and includes actions in relation to targeted Identification and Brief Advice (IBA) training, widely promoting the care pathway for the DARS, aiming to engage 15% of the estimated alcohol dependent population in treatment each year and developing mutual aid recovery communities. This plan will be reviewed and refreshed annually and will be monitored by the Alcohol Steering Group.

15. Public Health England: Joint Strategic Needs Assessment 2012/13

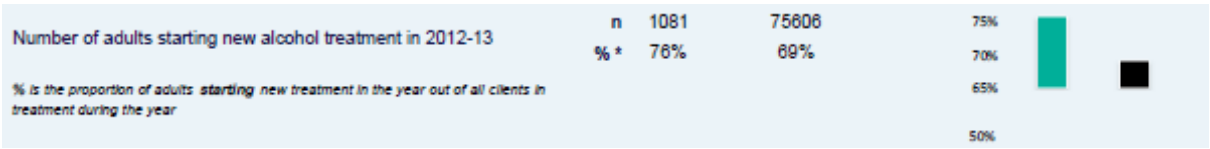
The data reflects the level of health harm from alcohol in the population. Hospital admissions can be a result of casual regular alcohol use above lower-risk levels as well as chronic heavy drinking in the population and is most likely to be found in increasing-risk drinkers, higher-risk drinkers, dependent drinkers and binge drinkers. High levels of alcohol specific admissions clearly indicate levels of alcohol misuse.

The rate of alcohol-related hospital admissions is used as an indicator in the Public Health Outcomes Framework. Some alcohol related hospital admissions are specifically caused by alcohol while others are contributed to by alcohol (attributable). Alcohol related hospital admissions for East Sussex largely follow the same trend seen both regionally and nationally, with lower rates than England but higher than that for the South East.



Hastings has the highest rates of hospital admissions due to alcohol in the county. However, when compared to the national picture, although the rates of admissions in Lewes have been increasing since 2006/07 the district is defined as a Local Authority with lower harm levels.

Published data shows a total of 1429 adults in alcohol treatment in 2012/13; an increase of 185 (+14.9%) on the previous year, which suggests that the service has been successful at engaging people in treatment. This rise is also significantly higher than the national picture where an increase of only 0.5% is evident. Also of note is that three out of four clients within this cohort were new to alcohol treatment in 2012/13 which is once again higher than national findings (69%).



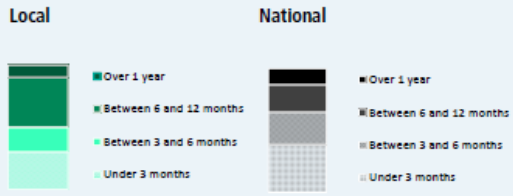
Use of other substances alongside alcohol is similar to the previous year with the majority of clients who use another drug (15%) citing additional use of cannabis.

Recommendation:
21. Review the needs of primary alcohol clients citing additional use of cannabis assess current practice to address this

Data also shows that locally, half of clients have been in treatment for less than 3 months, with the average length of time in treatment for this cohort calculated at 141 days. This is shorter than national findings where on average, clients have been in treatment for 183 days.

Length of time in treatment

		Under 3 months	Between 3 and 6 months	Between 6 and 12 months	Over 1 year	Average (days)
Local	n	714	334	259	122	
Local	(%)	50%	23%	18%	9%	141
National	(%)	39%	26%	22%	13%	183



Units consumed in the 28 days prior to entering treatment

		0	1-200	201-400	401-600	Over 600	Missing
Local	*n*	173	434	294	245	281	2
	%*	12%	30%	21%	17%	20%	0%
National	%*	7%	17%	18%	19%	36%	3%

**note: proportions here are calculated out of total clients with completed data rather than all clients in treatment*

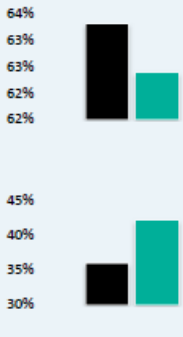
The above data therefore appears to show that compared to the national picture, in East Sussex we are seeing more new clients coming into treatment who are declaring less alcohol use and are spending shorter periods in treatment.

Recommendation:
22. Review clients accessing alcohol treatment to ensure the service addresses high and complex need

The successful completions data below provides an indication of the effectiveness of the treatment system in the local area. A high number of successful completions and a low number of representations to treatment indicate that the treatment services are responding well to the needs of those in treatment. 62% of clients successfully completed treatment during 2012/13, which is in line with the national findings. However, 42% of those individuals who completed treatment successfully in 2012 did not return within 6 months, which is encouraging as nationally, only 36% did not represent.

Clients completing treatment successfully in 2012-13	*n*	637	44314	
	% of all exits	62%	63%	
	% of all in treatment	45%	40%	
Clients completing treatment successfully *(between 1st January 2012 and 31st december 2012)* and not returning within 6 months	*n*	577	39800	
	%	42%	36%	

**note that in order to allow for a representation period, the treatment population time period refers to the calendar year rather than the financial year used in the rest of this report. Therefore the number of completions will differ from that in the above item which refers to the financial year.*



16. Foetal Alcohol Spectrum Disorder (FASD)

FASD is an umbrella term that covers foetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorders (ARND), alcohol-related birth defects (ARBD), foetal alcohol effects (FAE) and partial foetal alcohol syndrome (pFAS).

When a pregnant woman drinks, the alcohol in her blood passes freely through the placenta into the developing baby's blood. Because the foetus does not have a fully developed liver, it

cannot filter out the toxins from the alcohol as an adult can. Instead, the alcohol circulates in the baby's blood system. It can destroy brain cells and damage the nervous system of the foetus at any point during the nine months of pregnancy.

However, the incidence of FASD in the UK and internationally is not accurately known. Many children born with FASD are not diagnosed, or do not receive a correct diagnosis, which makes calculating the prevalence of the condition extremely difficult[16].

Locally, a Public Health Information Specialist has looked into hospital admissions and found that since March 2010, five children under 15 years have been admitted with Foetal Alcohol Syndrome (dysmorphic) in any diagnostic position. One child has been admitted as a foetus / newborn affected by maternal use of alcohol.

17. Adult Drinking Behaviours in East Sussex[17]

There are different data sources and methodologies that have been used to estimate the drinking behaviours of the adult population for local areas. This means that different sources are not directly comparable and may differ in the estimated prevalences of particular behaviours.

23% of the total adult population in East Sussex are estimated to be increasing and higher risk drinkers. Of those who are drinking, around 7% are doing so at high risk levels. There are no significant differences to the England average for the percentage of the population who are increasing or higher risk drinkers. For binge drinking, Lewes, Rother and Wealden have significantly lower percentages than the England average.

Table 13: Drinking behaviour estimates for East Sussex local authorities[18]

	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sx
Abstainers from alcohol (% of total adult pop)	16	16	14	15	14	
Increasing & higher risk drinkers (% of total adult pop)	22	22	23	22	23	23
Binge drinking (% of total adult pop)	16	21	15	16	15	
Lower risk drinking (% of drinkers)	74	74	73	74	73	
Increasing risk drinking (% of drinkers)	19	19	20	20	21	
Higher risk drinking (% of drinkers)	7	7	7	6	6	

The above is a refresh of previously published data. However, no actual figures are provided for comparison purposes, and so the Public Health Intelligence Team have advised that figures published in the LAPE report Topography of Drinking Behaviours in England19 should be used for local comparison purposes.

18. 'Front of House' Alcohol Service at East Sussex Healthcare Trust

A project, which has been funded for two years (to 31 March 2014), has tested an approach that reduces repeat emergency admissions for people with alcohol related conditions. The project extends the reach of the community alcohol team by funding two hospital-based staff. These staff identify alcohol related 'frequent attenders' – patients who have attended the emergency department more than three times in the previous six months. The staff then work assertively with these patients to engage them in effective alcohol treatment.

[16] National Organisation for Foetal Alcohol Syndrome UK: http://www.nofas-uk.org/
[17] Uses information from the Public Health Alcohol Related Health Harm Report: November 2013 Author: Clare Brown
[18] Data provided by Public Health
[19] http://lape.org.uk/downloads/alcoholestimates2011.pdf

About two thirds of these patients have been engaged in alcohol treatment, reducing further emergency presentations and admissions. The staff also work with ward staff to improve identification within hospital wards and improve engagement with the community alcohol team when appropriate as part of patients' discharge plans. Although the pilot did reduce the frequency of attendance and emergency admissions to hospital, it did not demonstrate the levels of savings anticipated. This targeted approach will not continue beyond the pilot.

The new DARS will include hospital liaison working across the acute hospitals and minor injury units.

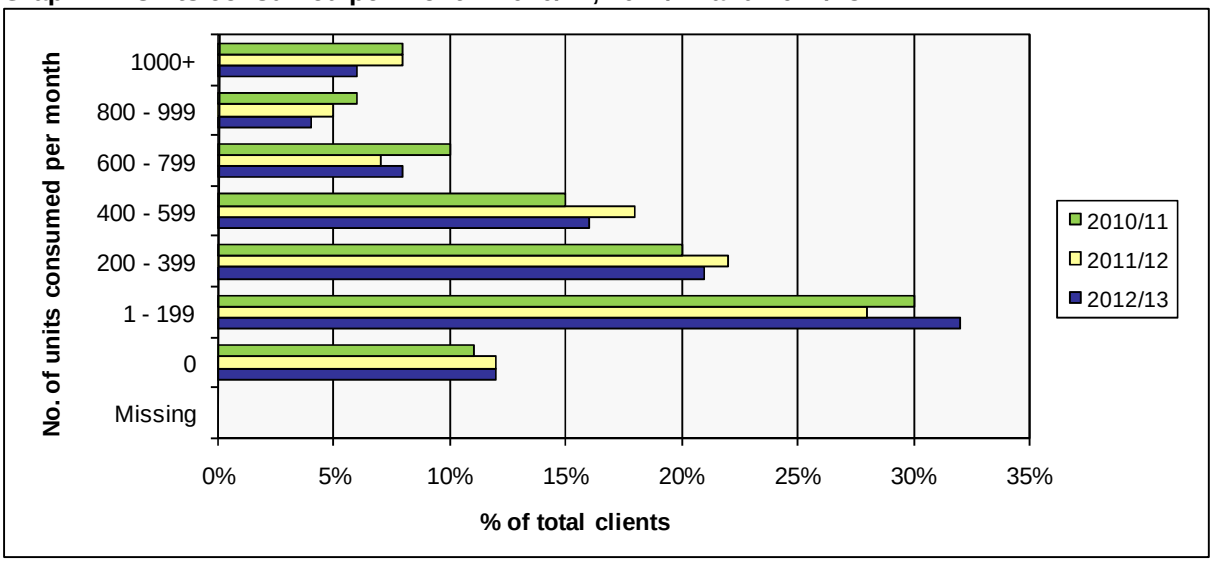
19. Alcohol Complexity Index

PHE has developed this index with the aim of reporting upon the level of complex issues within the treatment population. However, it is intended to be used as a guide to give a general impression of the complexity levels of the alcohol treatment population in each area of the country. Full explanation of The Complexity Index, including the methodology behind the calculations, can be found in the PHE published Alcohol Needs Assessment Data Guidance[20].

The population in treatment has changed slightly over three years as the service has attracted more people drinking at lower levels. The total number of complexity items that each client has scored is in line with national findings. The majority (65%) of clients met only 1 or 2 of the items within the complexity criteria, while only 6% of clients can be categorised as the most complex, scoring 4 or more within the criteria; a slight reduction on 2011/12 findings (9%).

However, there continues to be a shift in relation to drinking patterns, as there were more clients drinking between 1 and 199 units a month in 2012/13, and less drinking between 800 and 1000+. The proportion of clients drinking 1000+ units in the 28 days prior to assessment remains lower than the treatment population nationally (14%).

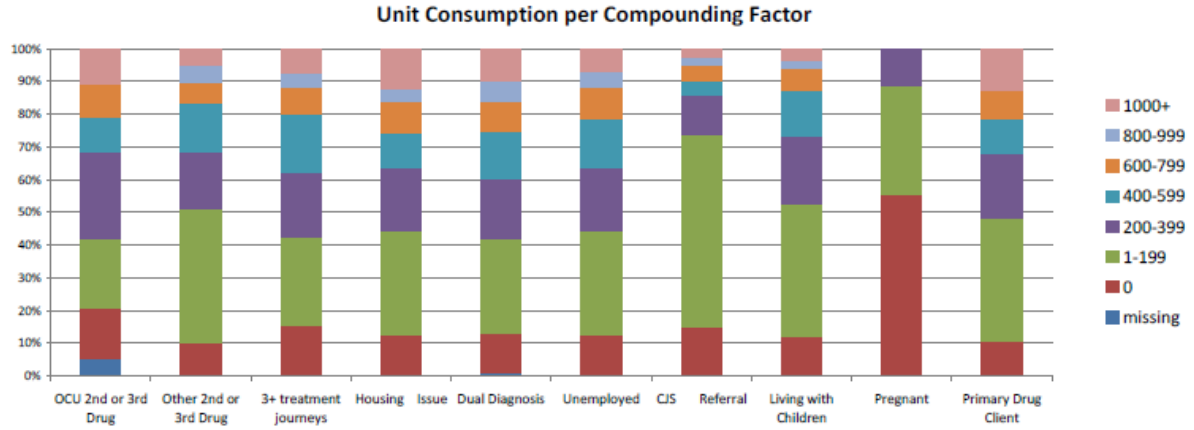
Graph 17: Units consumed per month: 2010/11, 2011/12 and 2012/13



Findings in East Sussex are broadly similar to the national picture in relation to the majority of complexity items. However, CJS referrals appear more common in East Sussex as this was the referral route of 15% of clients, compared to only 6% across England.

[20] www.NDTMS.net

Graph 18: Unit consumption per complexity item[21]



Other findings remain similar to the previous assessment. Although of note is that those highest risk drinkers (1000+) remain most likely to be referred into treatment from A&E. It is probable that these referrals are a result of having been admitted to hospital with an alcohol specific condition such as liver disease.

The treatment population continues to be largely male (77%), which is in line with national findings (75%). However, when looking at the total demographic makeup for each complexity item, the following changes to 2011/12 can be noted:

- There is a slight gender divide for those with a positive dual diagnosis status; 56% male compared to 44% female, and relates to a total of 114 clients. This split was 50:50 in 2011/12 and related to a total of 143 clients.
- Those presenting to treatment with a housing problem now include those in the older age bracket, covering those aged between 25 and 54; those presenting in 2011/12 were largely aged 25 to 44
- There has also been a shift towards the older end of the age range for those clients categorised as an OCU. The majority of clients within this cohort (47%) were aged 35 to 44; a shift from 25 to 34 in 2011/12
- 36% of clients with an identified housing problem left treatment in an unplanned way; an increase on the previous year (31%)

20. National Drug Treatment Monitoring System (NDTMS) Data

The following narrative will look at data taken from the adult treatment case management system (Nebula) and submitted to Public Health England (PHE). It represents those who have presented to the adult treatment services with alcohol as a primary drug and were receiving a treatment intervention between 1st April 2012 and 31st March 2013. Unless stated otherwise, data shown will relate to the most recent treatment episode for each individual.

20.1. In-Treatment Population

A total of 1336 clients aged 18 or over on the 1st October 2012 were in treatment for alcohol misuse in East Sussex in the 12 months to March 2013. This is an increase of 204 (+18%) on the in-treatment population of 2011/12. These clients were predominantly receiving treatment from the East Sussex Community Alcohol Team.

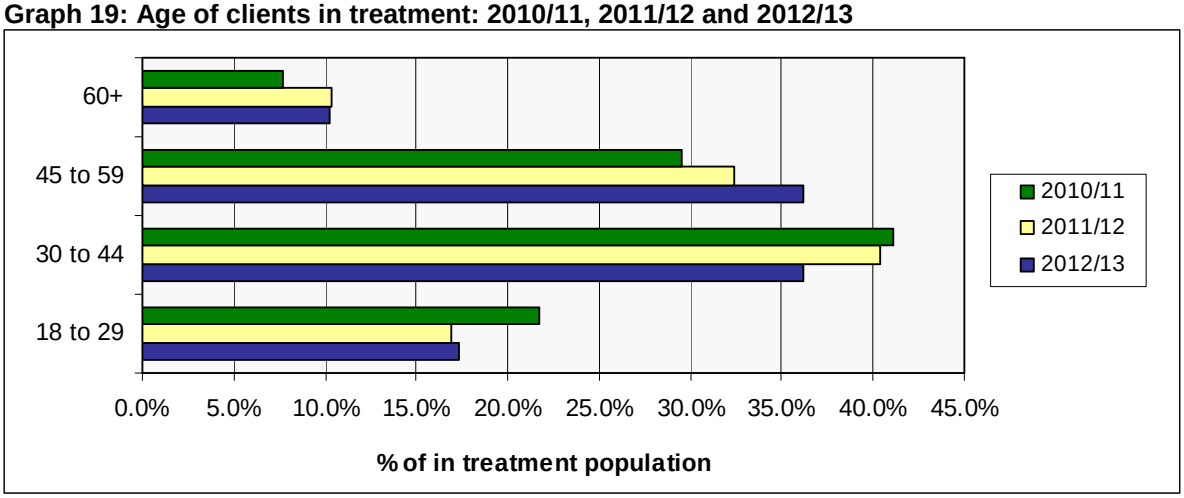
[21] Alcohol Complexity Index 2011/12: East Sussex: www.ndtms.net

20.2. Personal Profile

Males continue to account for the majority of the in-treatment population (62.2%) which is in line with national findings.

Previous findings suggested that the older population of East Sussex is being under-represented. Locally adopted recommendations in relation to engaging older drinkers in treatment appear to have had some impact on the in-treatment population. In 2012/13, equal proportions (36.2%) of clients aged 30 to 44 and 45 to 59 are evident. This is a shift from 2011/12 when four out of 10 clients (40.4%) fell in the 30 to 44 age bracket, and only 3 out of 10 (32.4%) were in the 45 to 59 age group.

Graph 19: Age of clients in treatment: 2010/11, 2011/12 and 2012/13



The Equality Impact Assessment (EIA) for the Drug and Alcohol Recovery Service also identified the following groups who may be under-represented in treatment:

- **People aged 60 or over who use alcohol**: 10.3% of the 2012/13 in-treatment population were in this age bracket. This is the same as the previous assessment
- **People who are lesbian or gay who use alcohol**: 2.9% of the 2012/13 in treatment population are recorded as being homosexual. This compares to 2.3% in 2011/12

Please note that data is not available for the following protected characteristics:

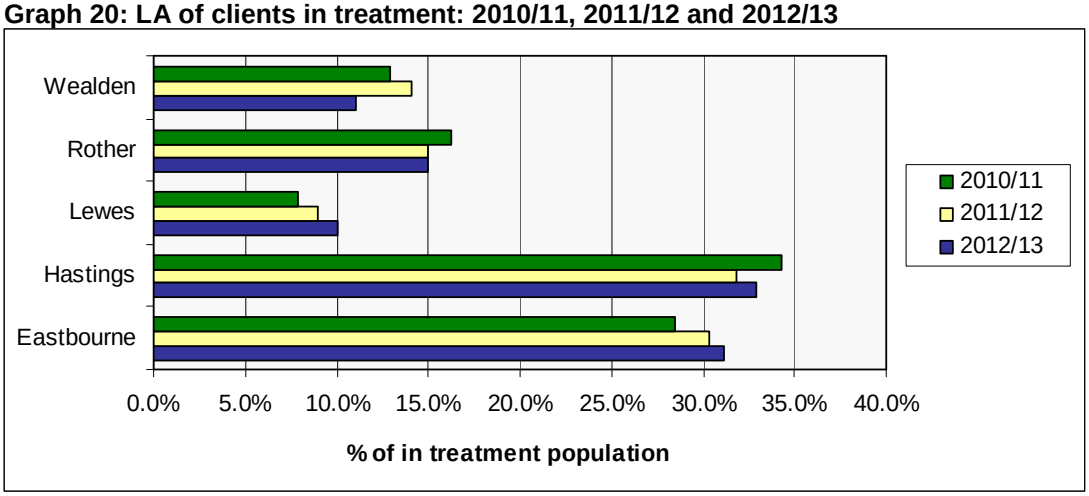
- Travellers who use alcohol
- People who are transgender who use alcohol

Recommendation:
23. Ensure data collected through DARS captures protected characteristics and Gypsies and Travellers

20.2.1. Personal Profile by Area

The EIA also identified that services are used much less frequently by people living in rural districts. Those individuals accessing treatment continue to mainly live in the urban areas of Eastbourne and Hastings. The proportion of clients residing in Lewes has seen an increase since 2011/12, Rother has remained broadly the same and Wealden has seen a reduction.

Graph 20: LA of clients in treatment: 2010/11, 2011/12 and 2012/13



In terms of numbers:

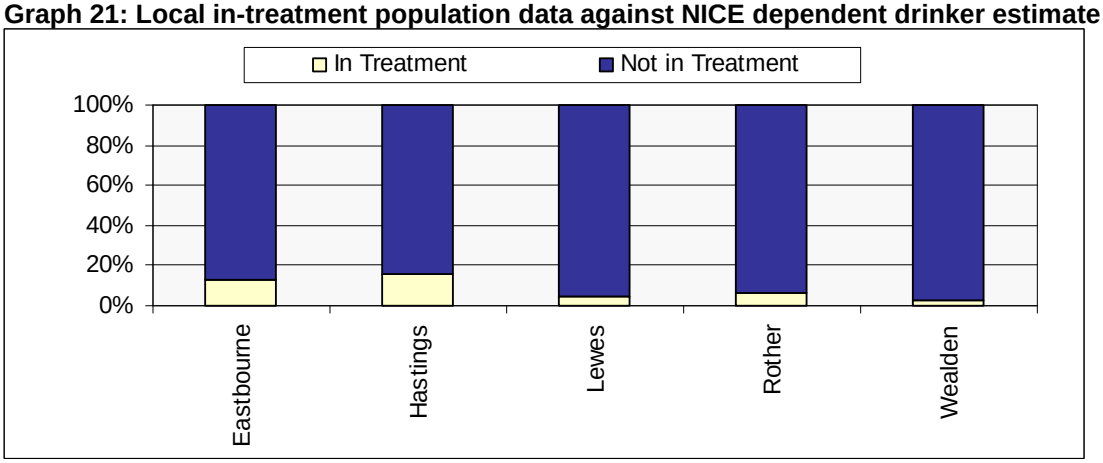
- Eastbourne has seen a rise from 343 clients in treatment in 2011/12 to 416 in 2012/13
- Hastings has seen a rise from 360 clients in treatment in 2011/12 to 440 in 2012/13
- Lewes has seen a rise from 101 clients in treatment in 2011/12 to 133 in 2012/13
- Rother has seen a rise from 169 clients in treatment in 2011/12 to 200 in 2012/13
- Wealden has seen a fall from 159 clients in treatment in 2011/12 to 147 in 2012/13

The Department of Health recommend that Commissioners plan for 15% of the dependent population to enter treatment each year[22]. NICE guidance[23] suggests that for planning purposes, 3.8% of the population 16+ are alcohol dependent. Applying this logic to the population of East Sussex gives us the figures below:

Table 14: Estimated dependent drinker estimate and local in-treatment data

	Eastbourne	Hastings	Lewes	Rother	Wealden
NICE Dependent Drinker Estimate[24]	3156	2796	3093	2920	4727
Local In Treatment Population (2012/13)	416	440	133	200	147
Local In Treatment Population (%)	13.2%	15.7%	4.3%	6.8%	3.1%
Local In Treatment Population (2011/12)	11.2%	13.4%	3.3%	5.9%	3.6%

Graph 21: Local in-treatment population data against NICE dependent drinker estimate



[22] 'Signs for Improvement', Department of Health 2010
[23] NICE Alcohol-use Disorders: Alcohol Dependence p12
[24] Calculation based on 3.8% of 2012 ESiF estimated 16+ population of East Sussex

Hastings is the only Local Authority achieving the 15% throughput target, although, Eastbourne, Lewes and Rother have all seen an improvement on 2011/12, Wealden has seen a decline..

20.3. Additional Substance Use

Much like previous years, the majority of clients did not declare a second or third substance. Of those that did, they largely declared use of Cannabis (14.7%) while a further 79 clients (5.9%) cited use of cocaine.

A baseline for primary alcohol clients declaring use of cannabis as a secondary substance has been established and this was set at 190 using 2011/12 in-treatment data. Although the impact will not be evident until the end of the year, a total of 170 clients declared cannabis as a secondary substance during 2012/13, which is a reduction of 20 (-11.8%) on the baseline.

20.4. Employment and Housing

Clients in treatment for alcohol misuse continue to be largely long term sick or disabled (25.8%), unemployed and seeking work (28.2%), or in regular employment (26.3%).

A baseline, to ascertain if the Community Alcohol Team has increased the numbers of people who are employed and start treatment, has been set. The impact of this is reviewed via the monthly and quarterly activity data (MAD) and considered at the quarterly Contract Review Meetings.

Almost 9 out of 10 clients stated they did not have a housing problem, while less than 3% were of no fixed abode. However, much like previous years, those clients with a housing problem or an urgent housing need are largely in Eastbourne and Hastings.

20.5. Discharges from Treatment

Local data shows that there has been a significant increase (+25.3%) in relation to the number of discharges from treatment. There were 1078 discharges during 2012/13, which relates to 1013 clients as 63 clients were discharged more than once during the 12 month period. This is an increase of 218 discharges on the previous year.

Successful completions of treatment have improved. Looking at all 1078 discharges during 2012/13:

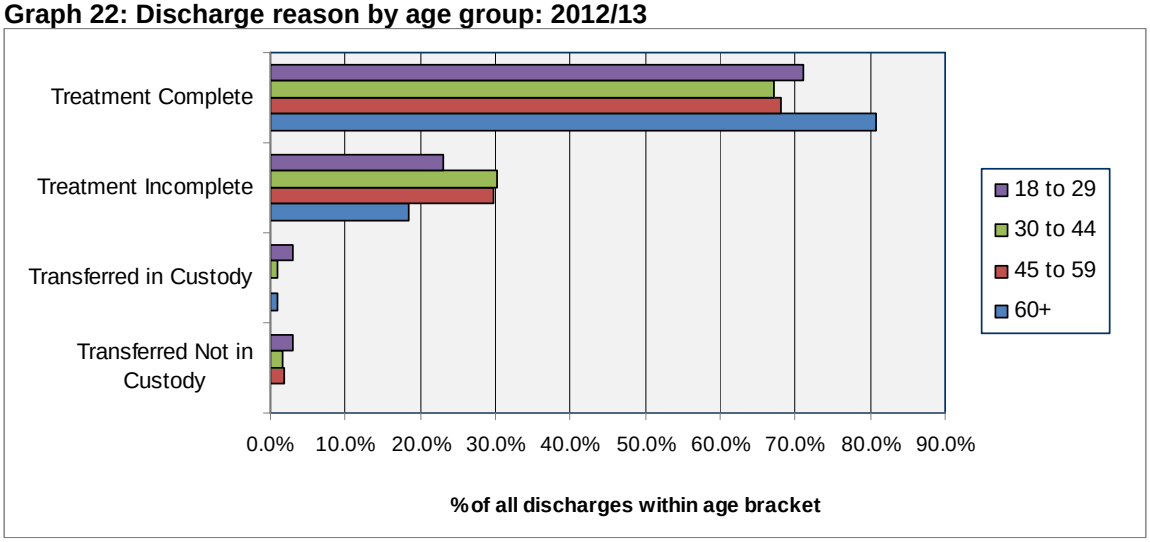
- 750 (69.6%) completed treatment; an improvement on 2011/12 (58.1%)
- 297 (27.6%) did not complete treatment; an improvement on 2011/12 (39.9%)
- 19 (1.8%) were transferred not in custody; similar to 2011/12 (1%)
- 12 (1.1%) were transferred in custody; similar to 2011/12 (1%)

Discharges continue to be in line with the personal profile of the in-treatment population. Females are slightly more likely to leave alcohol treatment in a planned way; 72.7% of females left after successfully completing treatment during 2012/13 compared to 67.7% of males.

When looking at discharge rates as a proportion of all discharges, the 60+ cohort continue to have the highest proportion of clients completing their interventions and leaving treatment in a planned way (80.7%) and the lowest proportion failing to complete their treatment journey (18.4%). This is also an improvement on the previous year when 67.9% and 30.8% of the 60+ cohort left treatment in a planned and unplanned way respectively.

Similar to previous findings, those leaving treatment Transferred in Custody are most likely to be aged between 18 and 29.

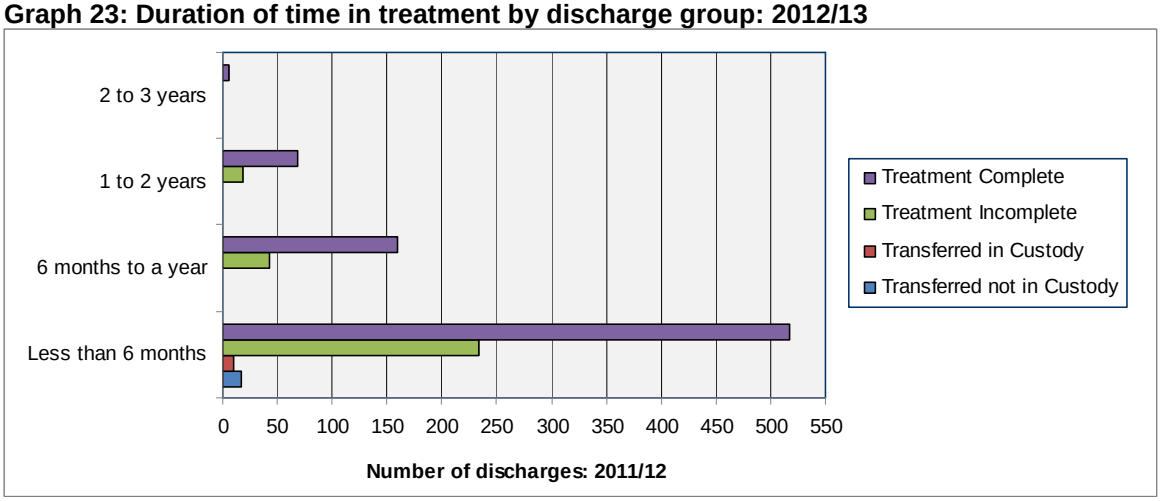
Graph 22: Discharge reason by age group: 2012/13



20.6. Duration of Treatment

Much like previous assessments, the majority of clients who were discharged in 2012/13 and who cited alcohol as their main substance, were in treatment for less than 6 months. Approximately 7 out of 10 discharges (72.2%) fall into this category during 2012/13, compared to 78% in 2011/12. 66.5% of these discharges in 2012/13 relate to a successful completion of treatment; an improvement on the previous year's findings when 57.8% of this cohort left treatment in a planned way.

Graph 23: Duration of time in treatment by discharge group: 2012/13



A number of treatment journeys that ended during the analysed period lasted less than 3 months. Similar to previous findings, just under half (46%) of all discharges in 2012/13 lasted less than 90 days with 66.7% of these ending in a planned way. Just over a third (33.5%) lasted less than 2 months, 67.6% of which were successful completions of treatment.

21. Inpatient Detoxification and Residential Rehabilitation: Drugs and Alcohol

Data recorded in Nebula shows that 141 clients were receiving drug and alcohol inpatient and residential care interventions during 2012/13. This is an increase on 2011/12 when there were a total of 118 clients accessing the same service.

The following is of note with the inpatient and residential care population:

- Only 12 clients (8.5%) were in the oldest (60+) and 16 clients (11.3%) in the youngest (18 to 29) age brackets. Clients largely following the general in-treatment picture with the largest numbers (41.8%) being in the 30 to 44 age group
- 68.8% of all clients are resident in Eastbourne (32.6%) or Hastings (36.2%). The lowest involvement of Tier 4 treatment was in Lewes where only 13 clients were involved in this level of treatment during 2012/13
- Almost Two thirds (65.2%) of clients listed alcohol as their main drug while a further 47 (33.3%) listed Heroin.
- A third (34.8%) of clients can be categorised as an OCU
- The largest numbers of clients (30.5%) undertaking this intensive form of treatment have stated they are long term sick or disabled, followed by a further 30.5% being Unemployed and seeking work.

Please note; the implementation of 'Core Dataset J' (CDS J) has condensed the Tier 4 post assessment options down to two structured modalities: pharmacological (Inpatient) and psychosocial (Residential Rehab) with the addition of a setting (inpatient unit or residential). One result of the change in the method of recording interventions is that new modalities were opened and closed, despite being in continuous treatment. These 'replacement' modalities could appear falsely as subsequent interventions with associated waits; therefore, the recording of interventions is not comparable to last year.

21.1. Residential Rehabilitation

A locally produced report shows that a total of 84 residential rehabilitation placements were funded in the 12 months to March 2013, 71 of which were started within this period. Of this group of 71:

- Almost 6 out of 10 placements (56.7%) were accessed by men, which would suggest that there are proportionately more women represented in residential care in comparison to community care.
- 38 (53.5%) of clients declared an opiate as their main drug, while a further 27 (38%) clients listed alcohol as their primary substance
- Clients accessing placements were largely aged in their 30s and 40s. Only 2 (2.8%) of all clients were aged 60+ and just over 1 out of 10 clients were in their 20s
- Just over half (54.7%) of placements that ended during the 12 month period ended in a planned way

During the first half of this period, (April 2012 to September 2012) almost half of all placements ended as unplanned (48.8%). These unplanned discharges for this period also reflect the significant increase in the numbers of clients who are applying for residential rehab as a means to address their substance misuse problems. The majority of these clients have re-engaged with community based services following their early discharge.

Data for the latter half of the period (October 2012 to March 2013) shows an improved rate of unplanned discharges (39.1%) compared to the first half of the year where there were 20 unplanned discharges compared to 7. Of those clients who have taken an unplanned discharge, significant efforts have been made by social work staff together with multi-agency colleagues to support them in maintaining their abstinence and sobriety and to reduce the knock on effects of relapse both to their own physical and emotional wellbeing, as well as to society in general.

The increasing numbers of clients that the SMS team have worked with is reflected in the increasing profile of the team with other agencies such as Children and Families and Adult social care services, as well as the traditional referral routes. The team continues to work with successfully completed clients with respect to integrating with a range of community based services.

Those clients who have returned to East Sussex have been successfully referred to the Home Works service for assistance into private rented housing. More recently support is being negotiated via East Sussex Recovery Alliance (ESRA) for peer support groups when re-integrating into the clients' local community. In all instances, clients continue to maintain abstinence with the support of Narcotics Anonymous (NA), Alcoholics Anonymous (AA), Smart Recovery and Action for Change, in addition to professional support from the social work team. Support is now regularly available to Carers of those with addiction issues through Carers assessments. Clients resettled into other areas continue to access education courses, voluntary work and fellowship groups they have accessed during third stage.

The team continue to ensure that clients are fully prepared and motivated to complete their residential rehabilitation in an effort to reduce unplanned discharges. It has included Reviews by the Senior Practitioner and Practice manager with Managers of the Rehab Providers we have historically used; with the aim of ensuring optimum clarity about the expected service provision and good outcomes from robust care plans. This work has had the dual effect of ensuring there is continued good liaison between provider and social worker/care manager over the course of the Client's Rehab Journey and clear understanding of personal responsibility and engagement by the Client working towards permanent sobriety from substance misuse.

22. Local Drug and Alcohol Initiatives

22.1. Test on Arrest

Test on arrest was introduced by the Drugs Act (2005). The purpose is to identify offenders who are misusing drugs and engage them in effective treatment. It provides a drug test for crack/cocaine and heroin when suspects aged 18 and over are detained for a trigger offence. Refusal of the test is an offence. Positive tests lead to the requirement to attend an initial assessment and follow-up assessment (if required) for drug treatment. Failure to attend the required assessment (and follow-up, if required) is an offence.

In East Sussex, test on arrest is funded jointly by East Sussex County Council and the Sussex Police and Crime Commissioner. Tests are completed by custody staff. Assessments are provided by drug workers supplied by the Community Substance Misuse Team (Sussex Partnership NHS Trust and CRI). The drug workers are available Monday to Friday during office hours. People who are detained and produce a positive test 'out of hours', are required to re-present for the required initial assessment when a drug worker is available. Despite the lack of weekend and evening cover, 95% of initial assessments are successfully completed.

22.2. Activity and outcome[25]

The following information summarises the activity at Eastbourne and Hastings during the first six months of 2013/14:

- There have been 943 tests, 274 (29%) positive for cocaine/crack and/or heroin.
- 126 tests (46% of all positive tests) were positive for cocaine only.
- 103 tests (38% of all positive tests) were for people not in treatment.
- 69 people (25% of all positive tests) were referred to start treatment

22.3. Treating addiction to cut crime

The additional cost of the 'Criminal Justice Integrated Team' (which includes the test on arrest service) in 2013/14 is reported in the DAAT Treatment Plan as £436,870. Of this, approximately £150K (or £75K for the first six months of 2013/14) is allocated to test on arrest. This is the additional cost to the treatment system of identifying the 81 detained

[25] Taken from Test on Arrest Update: Author, Jason Mahoney

people who were not in treatment and produced positive drug tests, approximately £925 per person. The cost of test kits and testing hardware has been borne by the Home Office.

Given what we know about the proportion of people who start treatment locally that go on to successfully complete treatment we can estimate the benefit.

We know from current performance data that 70% of people who start treatment locally are retained in effective treatment for twelve weeks or more (the point at which treatment gains are sustained), and 20% complete treatment successfully before then. 10% are not effectively engaged in treatment.

We also know that 60% of people who are engaged in effective treatment go on to complete treatment successfully. 14% are transferred to other treatment services (including treatment in custody). 26% are discharged before their treatment is completed.

Applying this to the 69 people who were referred to treatment, we can estimate that 43 people will complete treatment successfully:

- 69 are referred
    - 14 people successfully complete treatment within 12 weeks
- 48 people will be engaged in effective treatment for more than 12 weeks, of whom:
    - 19 will be discharged without completing treatment
    - 7 will be transferred to other treatment services
    - 29 will complete treatment successfully

Public Health England reports that any heroin or crack user not in treatment commits crime costing an average £26,074 a year (see NTA, 2012). Between them, every ten addicts not in treatment in 2010-11 committed:

- 13 robberies and bag snatches
- 23 burglaries
- 21 car-related thefts
- And more than 380 shoplifting thefts

The same report tells us that being in effective treatment for at least twelve weeks (or successfully completing treatment before then) significantly reduces offending – it led to an average of 26 fewer crimes per person in a year.

For the 69 of our 'test on arrest' treatment referrals in the first six months of 2013/14 who are expected to be engaged in effective treatment, this would equate to about 1,600 fewer crimes in a year.

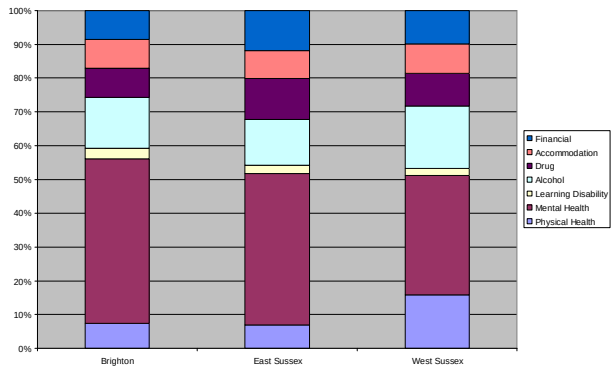
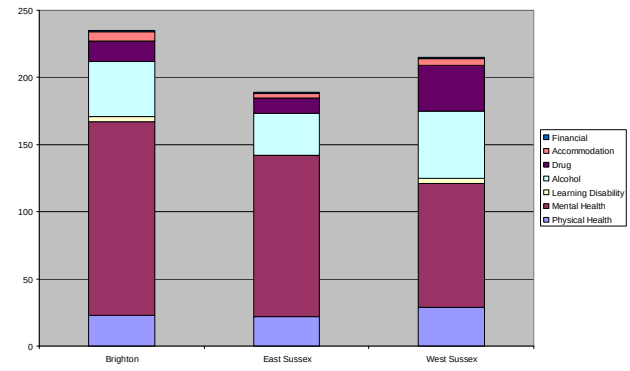
These crime reduction gains will be sustained for the 43 people who are expected to complete treatment successfully.

Sussex Police is currently conducting a cohort study of 60 test subjects from Hastings for the period 1 April 2011 – 31 March 2012 (5 subjects per month), looking at arrests, charges and positive tests in the twelve months before initial test on arrest, and in the following 12 and 24 months. For the first 16 people in the cohort (the first three months of the study), there were significant reductions in the number of arrests, charges and positive drug tests at 24 months. The study will be completed after April 2014.

Recommendations:
24. Share 'Test on Arrest' analysis with partners, with the view of considering recommendations

22.4. Pan Sussex Criminal Justice Liaison and Diversion Scheme[26]

The pan Sussex Criminal Justice Liaison and Diversion scheme has been in operation since August 2012. The scheme bases nurses in courts and custody suites, and aims to identify offenders with needs (for example health) that contribute to their offending behaviour. The nurses arrange appropriate treatment and, where possible, divert them from the criminal justice system.

Needs Identified	Referrals to Services
	

In the first half of 2013/14 a total of 426 offender assessments were made in custody and courts across East Sussex, leading to 189 referrals to services.

By far the most common need identified in assessments has been for mental health problems (322 individuals in the first half of 2013/14). However, drug and alcohol needs were also commonly identified: 98 individuals had a alcohol need and 68 a drugs need.

Referrals to services were lower (31 alcohol referrals and 12 drug referrals). However, the nurses tend to refer initially for the primary need, which in many cases is for mental health problems.

22.5. Alcohol Arrest Referral Pilot

An Alcohol Arrest Referral 9 month pilot was launched in June 2013 and involves an alcohol worker from the East Sussex Community Alcohol Team (ESCAT) being based at the Hastings Custody Centre for two hours on Saturday and Sunday mornings; between 0800 and 1000. The intention is for this worker to make contact with offenders who are taken into custody on the previous evening with an alcohol related offence, carry out an assessment of their needs and if appropriate, refer them into treatment.

Sussex Police met with ESCAT at the end of the third month to discuss progress. The feedback from custody was that they valued the pilot and the increased engagement with alcohol related offenders. Over the nine month period there were 292 alcohol related detentions. 47 people were offered alcohol treatment and 17 people were engaged in treatment. Given the low level of activity demonstrated by the pilot, and that both the Police and Court Liaison and Diversion Service and DARS already have a presence in the custody centres, there is no need for a discrete alcohol referral service.

[26] Data and information provided by SSPT Performance Analyst, Ed Dearnley

23. Prison Treatment for Recovery from Drug and Alcohol Misuse

Public Health England produces a report using data from the Home Office Management Drug Interventions Management Information System (DIMIS), which records information on adults receiving treatment for substance misuse in prisons in England. The report is concerned specifically with those who have been recorded as receiving one or more structured treatment modalities while in prison.

NHS England (Kent and Medway Area Team) is the responsible commissioner for HMP Lewes and HMP Bronzefield.

23.1. HMP Lewes

During 2012/13 329 new HMP Lewes receptions commenced drug treatment. However, a total of 360 individuals started drug treatment during the year and 34.7% were identified as opiate users. 119 clients (33.1%) were categorised as primary alcohol clients. 15% stated that they were currently injecting while 28% stated that they drank 25 or more units on a typical day.

When looking at all of those individuals in treatment during 2012/13, just under a third (32.4%) declared alcohol as their main drug, while a further 25.7% stated that heroin was their primary substance. Smaller numbers of individuals reported cannabis (18.6%) and cocaine (12.5%) as their most problematic drug.

Table 15: Primary drug self-reported by prison in-treatment population: 2012/13

	Total	%
Alcohol	233	32.4%
Heroin	185	25.7%
Cannabis	134	18.6%
Cocaine	90	12.5%
Crack	26	3.6%
Other	24	3.3%
Benzodiazepines	15	2.1%
Amphetamines	9	1.3%
Ecstasy	2	0.3%
Methadone	2	0.3%
In-treatment Population	**720**	

Also of note is that a total of 280 individuals were discharged from treatment during 2012/13, and all clients were discharged in an agreed and planned way:

- 154 (55%) left treatment drug free
- 58 (21%) were discharged from treatment alcohol free
- 2 (1%) left treatment as an occasional user
- 23 (8%) were transferred in custody
- 43 (15%) were transferred not in custody

Of those 257 clients leaving prison, 120 (47%) were released with no onward referral; 70 (27%) were transferred to another prison and 67 (26%) were released to the CJIT or other treatment provider.

23.2. Drug and Alcohol Recovery Team (DART) Review

The new CRI Drug and Alcohol Recovery Team (DART) was introduced on 1 October 2012. The DART is a multi-disciplinary team delivering a substance misuse recovery service that focuses on engagement, effective treatment and sustained recovery from drug and alcohol misuse.

Historically, the system used to report data to the NDTMS made it difficult to draw conclusions from the data. However, from the second quarter of 2013/14, all data has been migrated into a new reporting system which will make future reporting easier. Local performance indicators for 2014/15 are also being reviewed and may therefore provide supplementary indicators to the NDTMS data.

Recommendation:
25. Ensure that data from the prison service (on NDTMS) is used to shape improvements to services

25.1. HMP Bronzefield

Local women who are remanded in custody or convicted with short sentences are often imprisoned at HMP Bronzefield. Information about the prisoners receiving drug treatment at HMP Bronzefield (or any other prison) is not reported for the geographical area that they are returning to.

26. Mutual Aid: Drugs and Alcohol

Public Health England has produced a new toolkit of resources for use by partnerships, treatment providers and keyworkers to help them understand what links are in place between local treatment services and mutual aid groups, and to guide them on how to encourage clients to engage and participate as part of their recovery journey. The resources have been developed in consultation with a reference group including treatment providers and mutual aid representatives. The Community Development Officer in East Sussex will be leading a review of local arrangements in East Sussex.

Locally, a community development approach has been taken to develop sustainable recovery communities. The work has focused on supporting people in recovery to establish peer-led groups that can help other people, and promote visible recovery in local communities. A Community Development Officer came into post in 2013 and leads the development of recovery communities by engaging people who have a personal experience of drug or alcohol misuse.

Recovery communities undertake activities that bring people together with a focus on mutual aid and peer support. The two East Sussex Recovery Alliance (ESRA) forums – one in Eastbourne and the other in Hastings – are in the process of amalgamating, and this will contribute towards the process of gaining independent charitable status.

The recovery groups and activities are continuing to run effectively in East Sussex. Several members are undertaking training to be SMART Group facilitators and a bid has been placed for funding to establish a SMART pool which will provide groups and facilitators on a county wide basis. ESRA members also provided "expert by experience" support to the Joint Commissioning Manager during the bidding process for the new contract to provide substance misuse treatment across East Sussex.

A new recovery community group, Recovery Matters, has also been set up and is developing a programme of workshops which support the sustainable recovery of ex-offenders, which is due to start by April 2014.

27. Housing Objectives

27.1. Supporting People programme

Supporting People is a programme which helps adults who need particular kinds of support connected to their housing needs. This support is aimed at helping people to achieve independence within their community. It also funds two housing support services:

- Home Works - short term support for long term independence (for those aged 16 to 64)
- STEPS - short term housing support for older people

Across these floating support services in 2012/13, there were a total of 304 people who were identified as having a primary or secondary alcohol need and a total of 168 clients had an identified primary or secondary drug need.

27.1.1. Home Works

Home Works is a free and confidential housing support service for anyone aged 16 to 64 (single people, couples and families) who are homeless or could be at risk of losing their home and needs support to live independently. These services provide short term support of up to two years in some cases although evaluation shows that average utilisation of Home Works is around four months. Home Works has worked with over 5,500 vulnerable people over the last two years.[27] Access to this service is via self or agency referrals.

Table 16: Home Works clients with an alcohol or drug primary client group

	Primary Client Group	
Age Group	**Alcohol Issue**	**Drug Issue**
0	-	-
16-17	-	-
18-25	24	20
26-29	10	16
30-34	24	18
35-39	33	30
40-44	36	27
45-49	57	13
50-54	38	12
55-59	23	8
60-64	10	2
65+	-	-
Grand Total:	**255**	**146**

During 2012/13, Home Works supported 401 people who were at risk of homelessness and who had also an identified drug or alcohol primary need. 255 clients (64%) identified alcohol as their primary need and 146 people (36%) identified drugs.

Also of note:

Of those 255 people with alcohol issues as an identified primary need

- 22 (8.6%) identified drug issues as a secondary need
- 23 (9%) identified offending as a secondary issue

Of those 146 people with drug issues identified as a primary need

- 24 (16.4%) identified alcohol as a secondary needs
- 18 (12.3%) identified offending as a secondary issue

27.1.2. STEPS

STEPS is a housing support service for anyone aged 65 and over who is at risk of losing their home and needs support to live independently, including people with dementia or complex needs, regardless of their housing tenure. Whilst housing support may continue for up to two years in some cases, it is anticipated that most periods of support will be six months or less. Access to this service will be via self or agency referrals.

In 2012/13, STEPS supported 25 people identified with an alcohol issue.

27.2. Preventing Offender Accommodation Loss (POAL)

The POAL service (Preventing Offender Accommodation Loss) has operated at Hastings Borough Council since 2009. It provides a service to all those offenders that have a local

[27] Pathways to support and independence: A strategy for supported housing and housing support in East Sussex 2013 - 2018

connection to Hastings who are in HMP Lewes either on remand or sentenced to less than 12 months.

If they had accommodation prior to custody, the POAL team try to maintain it so that it is still available to them upon release. When someone is on remand and they were claiming housing benefit, the housing benefit can be paid up to 52 weeks and if sentenced it can be paid up to 13 weeks. If on occasion it is not possible to maintain the accommodation, the POAL team assist the offender to close the tenancy down in a managed way in order to avoid rent arrears and unnecessary conflicts of interests with landlords.

If they did not have accommodation prior to custody, a housing needs assessment is carried out with the offender and then source accommodation either in the private rented sector or supported accommodation depending on availability and individual need.

Information on those offenders, with an identified drug or alcohol need, is being captured from October 2013 and will be available in future needs assessments.

27.3. Statutory Housing Service

The Statutory Housing Service has been in operation since October 2013 and works with Offenders who have received a sentence of over 12 months and who have a local connection with Hastings. 2 officers have been funded by DAAT and Surrey and Sussex Probation, one in Hastings and one in Eastbourne.

The accommodation officers from Hastings Borough Council and Eastbourne Borough Council are based three days a week in the respective offices. They give housing advice and guidance to offenders as well as being able to find emergency accommodation when there is an urgent need. This service, together with Home Works supports for those in emergency accommodation will enable on site access to housing advice and the development of local accommodation networks for offenders.

In addition to this the specialist housing options officers:

- Accept referrals from Offender Managers
- Work with Offender Managers to ensure a Housing Action Plan is incorporated into the offender's overall Sentence Plan and sequenced with other interventions to maximise the likelihood of successful outcomes in the offender's sentence plan.
- Work closely with Offender Managers to ensure all relevant information is shared (including appointment times) and to ensure housing solutions are relevant
- Work closely with 'Home Works' and offender managers to ensure that the support offered is timely and relevant to the needs of each offender
- Encourage individual offenders to aspire to achieve independence through relevant referrals and joined up working
- Know the range of available housing solutions and the local housing market; understand housing benefits and negotiate with benefit agencies and advise offenders on the options available to them including affordability
- Offer advice to Offender Managers generally on housing related issues
- Work closely with housing and supported accommodation, private landlords and social housing sector landlords in the community to develop the network of housing provision that will consider accommodating offenders
- Work within a joint working referral protocol with Home Works and STEPS
- Deliver in service training for probation staff as necessary on housing needs screening and initial assessments
- Enable the client to access to rent in advance and deposits for the client group

28. Public Health Outcomes Framework (PHOF)

In January 2012, the Department of Health published The Public Health Outcomes Framework. There is a national PHOF tool now available[28] and within the course of a year each indicator will be updated and their annual data updated. A number of measures have been published, some of which are pertinent to and are likely to be monitored by the DAAT, such as the proportion of all in treatment who successfully completed drug treatment and did not re-present within 6 months for opiate and non-opiate users. However, some measures are yet to be published and these include:

- People entering prison with substance dependence issues who are previously not known to community treatment
- Alcohol-related admissions to hospital

Locally, there is the intention to produce an East Sussex PHOF tool, which will pull together PHOF data in the county and any other local data that can be added from Public health England sources. However, the availability of this is to be confirmed at a later date.

YOUNG PEOPLE

29. Public Health England: Joint Strategic Needs Assessment 2012/13

In order to help support planning for effective drugs prevention, treatment and recovery, Public Health England (PHE) have produced a Joint Strategic Needs Assessment Support Pack which reports on the treatment population of young people aged under 18 years and resident within each Local Authority area.

Within this summary we can see that the numbers of young people in specialist substance misuse services within East Sussex has seen a year on year reduction in line with the national drugs strategy restructure of young people's early help and treatment responses to substance misuse. In East Sussex targeted responses to drug and alcohol use were also realigned alongside other young people's risk factors such as offending behaviour and emotional well- being.

Despite the significant changes to local service delivery, the proportion of young people in treatment as a proportion of the whole treatment population of East Sussex is still significantly higher than the National picture.

	2011-12		2012-13	
	Local	National	Local	National
Number of young people in specialist services YP: aged under 18, primary drug & alcohol clients	313	20,688	235	20,042
Of all adults and young people in treatment, the proportion of which were young people	19%	9%	15%	9%
Number of YP in the secure estate receiving treatment	N/A	N/A	3	1332

Treatment activity has remained robust despite the change in referral thresholds. The DAAT partnership data that was previously reported for quarter 1 2013/14; showed a total of 255 young people in treatment aged under 18 years.

[28] Public Health Outcomes Framework Tool: http://www.phoutcomes.info/

The significance of that treatment number is understood when compared with the ES Children's Services OFSTED family comparator group:

Table 17: Young people in treatment Q1 2013/14

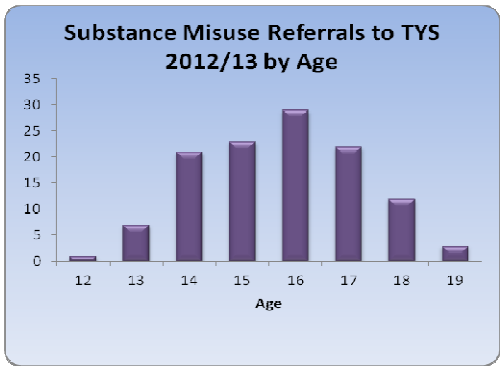
East Sussex	255
Devon	208
Suffolk	110
Norfolk	82
Cornwall & Isles of Scilly	134
Warwickshire	89
Somerset	41
West Sussex	170
Gloucestershire	101
Bedfordshire	68

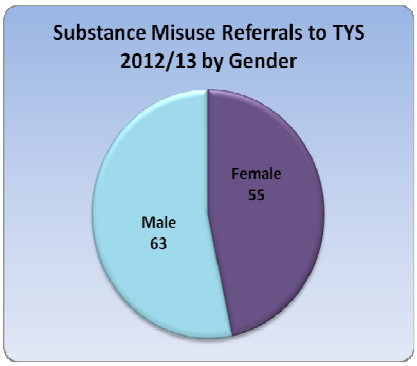
The structure of substance misuse responses now in place within East Sussex reflects the adoption of the premise that substance misuse interventions should exist within a wider service structure that can address a range of service user needs.

Services are also locally commissioned to reflect a continuum of need with early help services offering the initial response to young people's drug and alcohol experimental use.

During the same period, Targeted Youth Support, the local early help provider, allocated 118 referrals with a primary issue of substance misuse. These individuals tend to be slightly older than the overall referrals to the service with the most frequently occurring age being 16 rather than 15.

Targeted Youth Support Charts: Substance Misuse referrals 2012/13





30. Young People

30.1. Demographics

In 2013/14 there was a new NDTMS data set implemented within YP substance misuse services which afforded the opportunity to record multiple substances at initial presentation.

At quarter 1, 2013/14 cannabis was the most common substance reported at 60%, alcohol at 30%, NPS at 5% and other substances such as opiates at 1%. Nationally cannabis and alcohol remain the most commonly recorded substances, with low numbers reporting Class A drug use.

The ages of young people accessing treatment are most commonly 17 and 18 years, with 50% of the treatment population being from this age group. The lowest age is 10 years and the highest aged 20 with care leaver status.

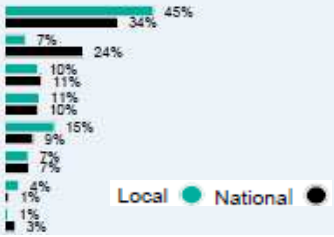
The trend towards the higher adolescent age group reflects the change in treatment population to a more problematic one and also the earlier intervention via the TYS offer which as shown in the above table is most likely to engage the a 15/16 year cohort.

30.2. Referral Pathways

The referral numbers remain relatively healthy because of the manner in which the specialist service is commissioned as an integrated children's service. This model has the advantage of recognising that young people ordinarily do not present with single issue needs and are rarely motivated to self-refer into treatment services.

Young people come to treatment from various routes. From the JSNA data below, during 2012/13, the largest proportions of referrals were made via the Youth Justice route with 45% of referrals being made this way; higher than the national picture (34%).

Referral Sources 2012-13	Local		National
	n	%	%
Youth Justice (incl the Secure Estate)	110	45%	34%
Education Services	16	7%	24%
Self, Family & Friends	25	10%	11%
Children & Family Services	26	11%	10%
Other Substance Misuse Services	37	15%	9%
Health & Mental Health Services (excl A&E)	18	7%	7%
Accident & Emergency	11	4%	1%
Other	3	1%	3%



- Other Substance Misuse Services include: adult treatment providers, YPs treatment providers, non-treatment substance misuse services and Frank

In the 2013/14 NDTMS quarter 1 report, the most commonly reported referral source was Children's Social Care Services, that refer 38% of the treatment population and YOT reducing to 17% in line with much lower agency activity levels as reported below.

30.3. National Drug Treatment Monitoring System (NDTMS) Data

Data taken from the local Children's Services case management system, CareFirst, and submitted to the NDTMS on a monthly basis shows that there were 258 young people in treatment in 2012/13.

As the table below shows, the majority of young people (34.9%) were recorded as living in the district of Hastings. 23.3% stated they lived in Eastbourne, 15.5% in Rother, 13.2% in Wealden and 11.2% in Lewes.

There were also 5 young people who were from out of area.

Table 18: YP in-treatment population by Local Authority 2012/13

Local Authority	Number	%
Hastings	90	34.9%
Eastbourne	60	23.3%
Rother	40	15.5%
Wealden	34	13.2%
Lewes	29	11.2%
Out of Area	5	1.9%
Total	**258**	

The majority of youth offending clients (38.8%) were referred into treatment by the Youth Offending Team with drug or alcohol treatment being an element of a young person's sentence requirement.

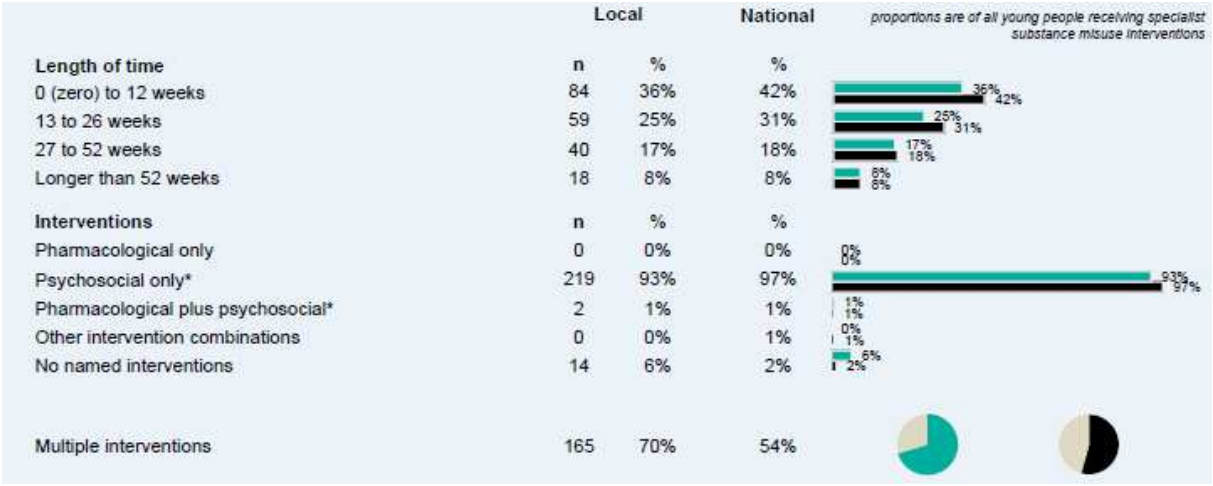
Table 19: Referral source of YP in-treatment population 2012/13

Referral	Total	%
YOT Sentence Requirement	100	38.8%
Targeted Youth Support	34	13.2%
Children and Family Services	25	9.7%
Parent or Relative	19	7.4%
Children's Mental Health Services	15	5.8%
Universal Education/School	15	5.8%
A&E	11	4.3%
Secure Childrens Home/Lansdowne	8	3.1%
YP Housing	6	2.3%
LAC/Care Leaver Services	5	1.9%
Crime Prevention	3	1.2%
GP	3	1.2%
Self	3	1.2%
YP Alternative Education	3	1.2%
Concerned Other	2	0.8%
Hospital	2	0.8%
School Nurse	2	0.8%
Outreach	1	0.4%
YP Treatment Provider	1	0.4%
Total	**258**	

30.4. JSNA reported interventions

The graphs below show the time young people in East Sussex spent receiving specialist interventions (latest contact) during 2012/13. Although young people generally spend less time in specialist treatment than adults because their substance use is not entrenched, those with complex care needs often require support for longer.

Within the East Sussex treatment cohort, 61% of young people were in treatment for 26 weeks or less during 2012/13. Just over a third of individuals (36%) were receiving specialist interventions for less than 12 weeks, while a further quarter (25%) were in treatment for between 13 and 26 weeks. However, as the graph below shows, these are both lower than national findings (42% and 31% respectively).



Also of note is that East Sussex follows the same trend as the rest of the country in relation to interventions delivered to young people. 93% of young people received psychosocial only interventions, which includes family interventions and harm reduction as well as other

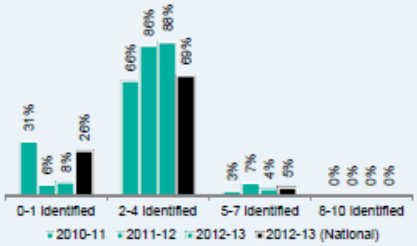
specific psychosocial intervention types. Most of the local treatment population receive multiple interventions in line with the complexity profile of the client outlined below.

30.5. Risk Harm Profile

As the graph below shows, those young people in treatment appear with more complex needs than reported in previous years, with a larger proportion having between 2 and 4 risks / vulnerabilities identified; this compares with YP identifying between 0 and 1 in 2010/11. The complexity of the local treatment population also is significantly greater than that reported by other Local Authorities.

Number of risks / vulnerabilities identified by each young person	Local n	Local %	National %
0 (zero) to 1 identified	14	8%	26%
2 to 4 identified	157	88%	69%
5 to 7 identified	7	4%	5%
8 to 10 identified	0	0%	0%

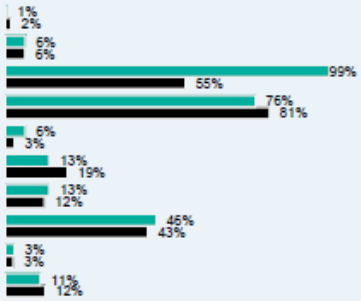
proportions are of all young people entering services for specialist substance misuse interventions



Much like previous years, young people reported using 2 or more substances. Locally, 99% of YP are involved in poly drug use, compared to 55% nationally, while 76% of YP began using their main problem substance under 15 compared to 81% nationally. Although the county is in line with the national picture for all other risk / vulnerability items, the graph below emphasises the susceptibility of young people to engage in substance use from a young age (under 15), which heightens the need for early intervention within this cohort.

Number of young people with each risk / vulnerability item	Local n	Local %	National %
Opiate and/or crack user	1	1%	2%
Alcohol users*	11	6%	6%
Using 2 or more substances[U]	176	99%	55%
Began using main problem substance[U] under 15	136	76%	81%
NFA / unsettled housing	11	6%	3%
Not in education, employment or training	24	13%	19%
Involved in self harm	24	13%	12%
Involved in offending	82	46%	43%
Pregnant and/or parent	5	3%	3%
Looked after child	19	11%	12%

proportions are of all young people entering services for specialist substance misuse interventions



**There are no safe drinking levels for under 15s and young people aged 16-17 should drink infrequently on no more than one day a week (CMO, 2009). This measure captures young people drinking on an almost daily basis (27-28 days of the month) and those drinking above 8 units per day (males) or 6 units per day (females), on 13 or more days a month.*

U substances for young people includes alcohol.

PLEASE NOTE: owing to different methodologies used to calculate the numbers of risks and the number with each risk percentages may differ, this is because the numbers of young people entering this specialist provision will be slightly different owing to different eligibility criteria.

Also of note within the 2012/13 treatment group:

- 11% were categorised as a looked after child (LAC); similar to the 2011/12 cohort (13%)
- 13% were not in employment, education or training (NEET); a reduction on the previous year (22%)
- 46% are involved in offending; similar to the 2011/12 in-treatment population (47%)

30.6. Treatment Profiles

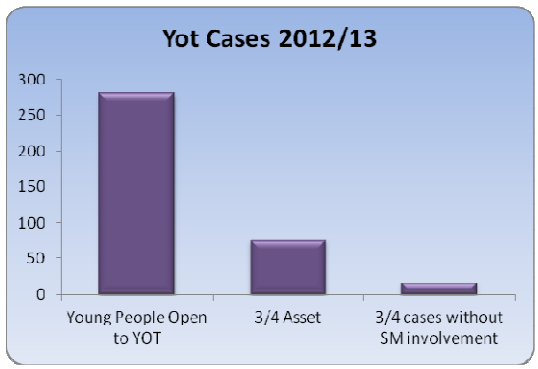
Within the previous needs assessment we focussed upon several specific service user groups in order to ascertain the effectiveness of screening, referral and treatment with "hard to reach groups".

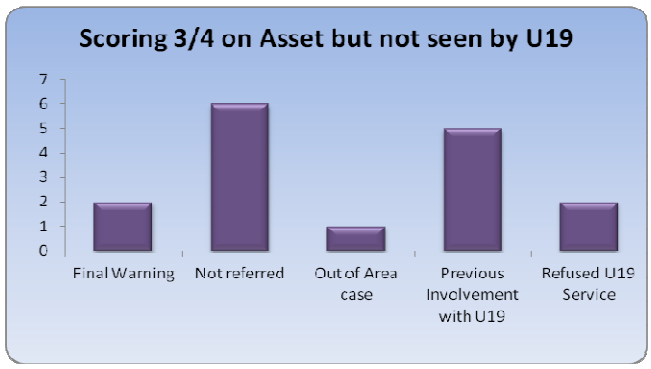
30.7. Youth Offending

In relation to the youth offending cohort, there were 281 young people open to the East Sussex Youth Offending Team (YOT) in 2012/13, receiving offending behaviour interventions which required an assessment.

Of these, 76 (27%) scored a 3 or 4 on Asset for Substance Misuse. Of these, 60 (78.9%) had some sort of involvement with the U19s Substance Misuse Service (SMS). Of the 16 young people not seen by the service, the main reason was because they were not referred by the YOT case worker. Five of the sixteen (31.3%) had prior involvement from the U19s SMS.

Youth Offending Team Charts: 2012/13

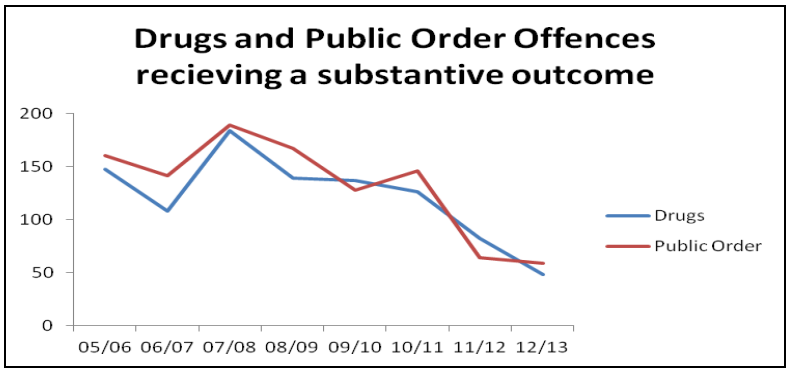




For the purposes of this needs assessment we undertook a particular review of the misuse of cannabis and/or alcohol amongst the youth offending cohort at this time. Patterns of young people's drug and alcohol use often change, so services that work with young people need to be ready to respond effectively to changing need. It there was an anecdotal report by Sussex Police and Detached Youth Work Services that young people were less visible in the streets consuming alcohol and there had been a rise in the reported availability of cannabis.

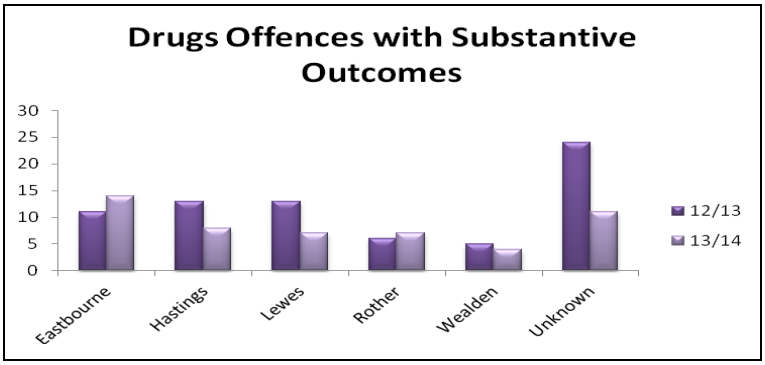
It can be difficult to get an accurate picture of alcohol related offences as young people are rarely charged with specific alcohol offences, rather they are charged with the other offences they commit whilst under the influence of alcohol such as Criminal Damage or Violence.

Alcohol offences are grouped together along with other offences under the category of Public Order offences. As the chart below for the whole of East Sussex shows, these types of offences have been falling in line with drugs offences.

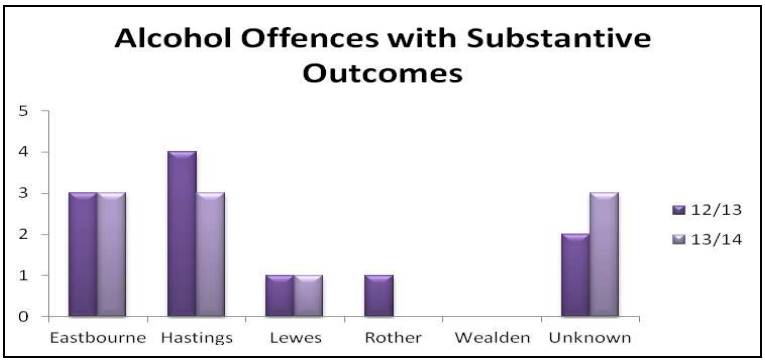


The chart below shows that if you look purely at Drug and Alcohol offences the numbers receiving a substantive outcome have actually increased in the last year for alcohol and fallen for Drug offences. I have included the 07/08 offences which was when the numbers receiving substantive outcomes were at their highest.

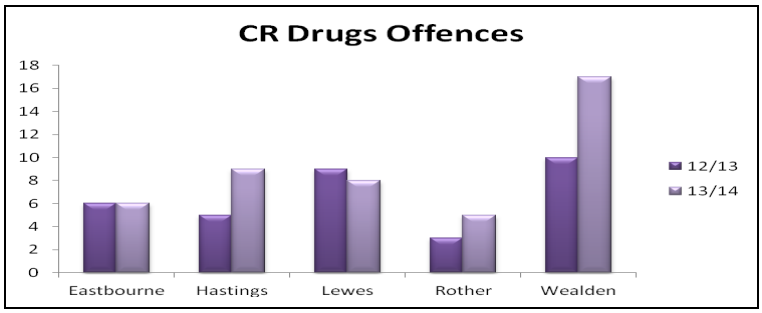
The chart below shows that there has been a decrease in the number of Drug offences receiving a substantive outcome in all of the areas apart from Rother and Eastbourne.



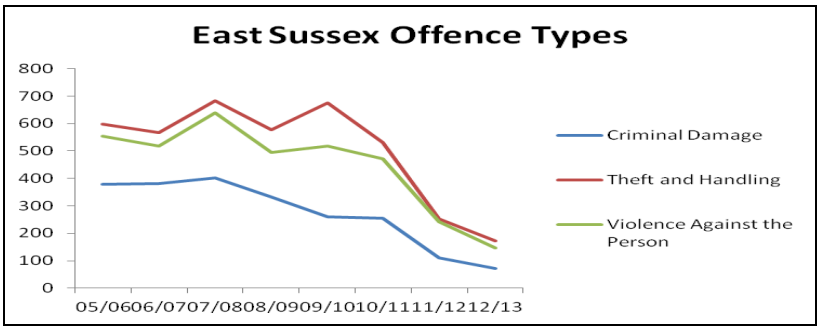
The numbers of young people receiving a substantive outcome for alcohol offences are so small that it is not possible to draw a meaningful conclusion from the figures.



There has been an increase in Community Resolutions (CR) recorded on Aspire the TYS data base for Drug offences. If we match all of those cases that have a valid postcode with a district or borough then we can see that Rother and Wealden also saw increases in the number of young people receiving CR for drugs offences.



If alcohol use is decreasing you might expect to see a greater fall in the number of Criminal Damage and Violence offences compared with Theft and Handling offences but as the chart below shows that is not the case.



It may be that young people are choosing cannabis over alcohol but apart from a slight increase in the number of CR being used for drug offences we don't have the evidence to support that they are being arrested in significantly greater numbers for it, so from an offending point of view it remains anecdotal.

30.8. School drug/alcohol related exclusions

The Under 19's SMS prioritise a specific response to all drug and alcohol related school exclusions, both fixed and permanent. During 2013/14 the following exclusions were deemed to be drug or alcohol related (reporting by District Borough location of school)

Table 20: Drug or Alcohol related School Exclusions

School District	Fixed term exclusion (no. of students)	Permanent exclusion (no. of students)
Eastbourne	9	5
Hastings	11	2
Rother	6	3
Lewes	5	0
Wealden	12	2
Totals	**43**	**12**

The previous needs assessment reported similar data relating to substance related school exclusions, both permanent and fixed, but only for an 8 month period September 2011 to March 2012. During this period, there were a total of 33 substance related exclusions, with 5 being a permanent exclusion and all for drug related offences. 3 of the permanent exclusions were in Rother and 2 were from Eastbourne.

30.9. Hospital Admissions for Drug and Alcohol related presentations – Under 18's.

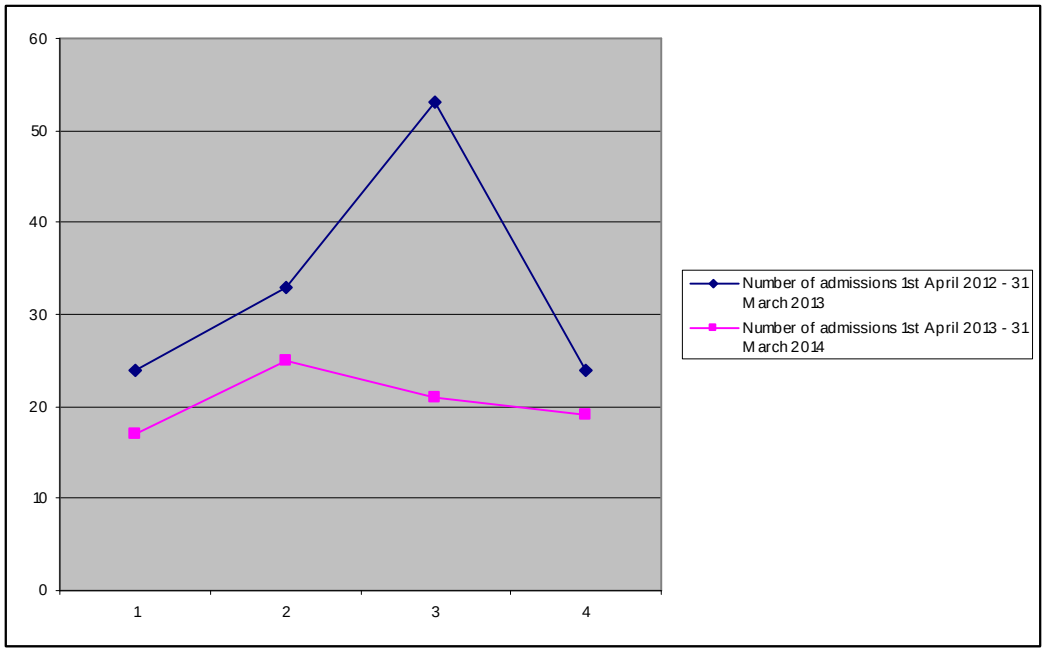
The Under 19's SMS and CAMHS service operate a joint screening response to all drug overdose and alcohol related admissions under the age of 18 years. This ensures that all young people who are admitted for mental health or substance misuse related issues receive a preventative response.

Table 21: Number of substance misuse and alcohol related admissions 2012- 2014

	1st April 2012 – 31 March 2013	Repeat admissions 1st April 2012 – 31 March 2013	1st April 2013 – 31 March 2014	Repeat admissions 1st April 2013 – 31 March, 2014
Quarter 1	24	1	17	2
Quarter 2	33	2	25	3
Quarter 3	53	3	21	0
Quarter 4	24	1	19	1
Total	**134**	**7**	**82**	**6**

This information shows there was s 38% decline in admission to A & E for the year 1st April 2013 – 31 March 2014. It appears to be the winter period in particular where the numbers of alcohol related admissions reduce sharply. We will need to continue to monitor the admissions in order to establish if this decline continues.

Number of substance misuse and alcohol related admissions 2012-2014



All of those young people with a drug/alcohol related admission would have been allocated an early help or a treatment response depending on the profile of risk at admission. The profile of risk would be determined by Children Index checks/other agency information and information recorded by nursing staff at admission.

30.10. Care Leavers

An internal social care audit of need was undertaken in 2013/14 in order to inform the multi-agency response required to meet the needs of the Local Authorities most complex and vulnerable young people.

Of the 46 young people subject to the case audit, aged 16 years to 21, the following headlines indicate the complexity of presentation but also the number of individual agencies, assessments, data sets, care plans and resources that are currently responding to each individual episode of agency referral.

U19's SMS provided assessment and/or intervention to 20 young people (43%). 5 cases received a dual diagnosis response from an RMN and 6 cases a lower threshold para prof response. Of concern was that 2 cases had 4 referral episodes within 4 years, however, worker stability enabled one single 2 year treatment episodes in 3 cases.

The summary report reflected below highlights some issues that require consideration for further integration of substance misuse assessment and planning frameworks within care leaver pathway and planning systems.

- All five young people who received services from three specialist agencies all received services from the Youth Offending Team.

- Those care leavers involved with specialist agencies for a long period, received a large number of assessments with one young person receiving 39 assessments alongside their LAC/Pathway plan. This young person also received services from eleven different workers within a 4 year period.

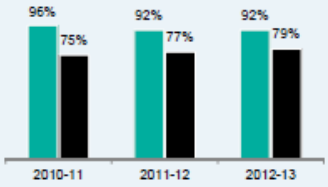
- The longer that young people were in contact with agencies the more assessments and workers they had. (National data sets, specific assessment and planning frameworks were seen as a key issue in these cases)

- Non-engagement with services resulted in multiple assessments.

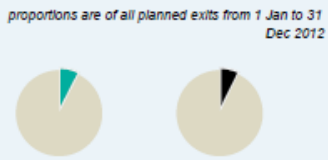
30.11. Planned Exits

The planned exit rate for young people in the county remains high; 92% in 2012/13 compared to 79% nationally. Only 8% of clients who left in a planned way re-presented to treatment within 6 months which is also in line with national findings.

Planned Exits	Local	National
Number of young people leaving specialist substance misuse interventions in a planned way	97	10207
Proportion of those leaving in a planned way as a percentage of all exits	92%	79%

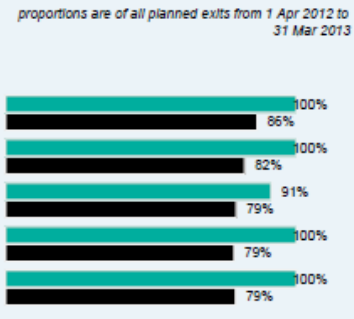


Planned exits with re-presentation	Local		National
	n	%	%
Young people leaving specialist substance misuse interventions in a planned way who re-present to young people's or adult specialist services within 6 months	10	8%	7%



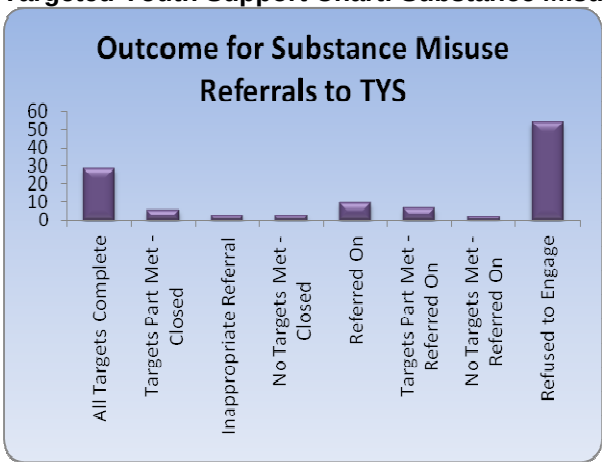
JSNA data also shows that all of those clients leaving treatment in a planned way have changed their behaviour and report no longer engaging in behaviour that is deemed to be 'a risk'.

Planned exits with risk / behaviour change	Local		National
	n	%	%
Involved in unsafe drug use at treatment start	25		
No longer involved at planned exit	25	100%	86%
Involved in self harm at treatment start	6		
No longer involved at planned exit	6	100%	82%
Involved in offending at treatment start	23		
No longer involved at planned exit	21	91%	79%
Involved in unsafe sex at treatment start	3		
No longer involved at planned exit	3	100%	79%
Involved in sexual exploitation at treatment start	1		
No longer involved at planned exit	1	100%	79%



Of the 118 referrals accepted by Targeted Youth Support with a primary issue of substance misuse, 114 (96.6%) had an outcome recorded on Aspire. 19 were referred on, equating to 17% of those young people worked with for substance misuse issues. Other outcomes are shown below with individuals' largely refusing to engage in treatment.

Targeted Youth Support Chart: Substance Misuse referrals 2012/13



30.12. Summary

The local response to the national Drug Strategy proposed integration of drug and alcohol treatment responses for young people into mainstream CS responses, a holistic response to children's needs was sought. This transition has been undertaken with relative success in East Sussex and we have seemingly avoided encountering a negative impact upon the number of targeted prevention and treatment interventions delivered. Furthermore, it has enabled locally a significant number of young people to receive a more responsive early help service from the Targeted Youth Support Service and prevent escalation into treatment provision.

However, there are targeted vulnerable groups of young people such as care leavers that continue to receive multiple agency assessment and intervention responses and this could require a further alignment of both local and national care and treatment planning frameworks. A further feature of this particular cohort is that the statutory planning framework for care leavers is to the age of 24 years, hence the current offer is retained within the young person's commissioned service.

The next consideration in relation to the young person's substance misuse agenda both in terms of future needs and local response is the threatened reduction in resource within the financial allocations of 2015/16 as LA and ring fenced allocations reduce.

FAMILIES

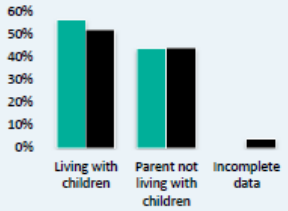
31. Public Health England: Joint Strategic Needs Assessment 2012/13

Data shows that a quarter of adults in drug treatment in East Sussex have children living with them. However, this rises to more than half (56%) when looking at adults receiving treatment for alcohol misuse.

	Local	Proportion of treatment population	National	Proportion of treatment population
Adults who live with children	323	25%	64,862	33%
Adults who are parents but do not live with any children	459	36%	41,532	21%
Adults with incomplete data	1	0%	4,691	2%

Adults receiving alcohol treatment who are in contact with children		Local	National
Living with children	*n*	370	32113
	%*	56%	52%
Parents but not living with children	*n*	287	27197
	%*	44%	44%
Incomplete Data	*n*	0	2517
	%	0%	4%

*note: proportions here are calculated out of total clients with completed data rather than all clients in treatment

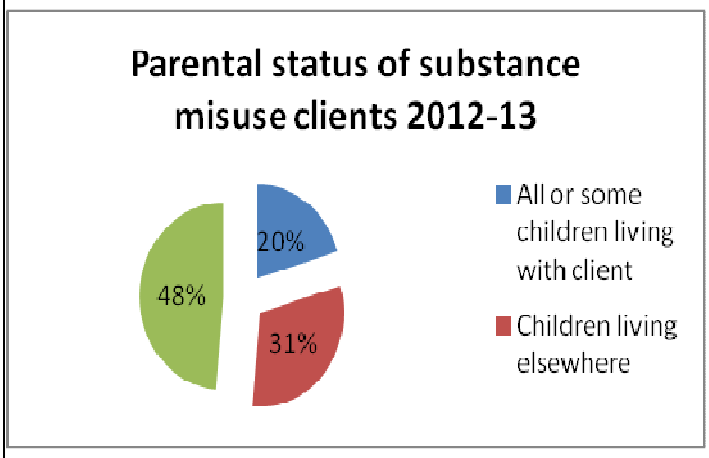


32. Parents/ carers with substance misuse problems

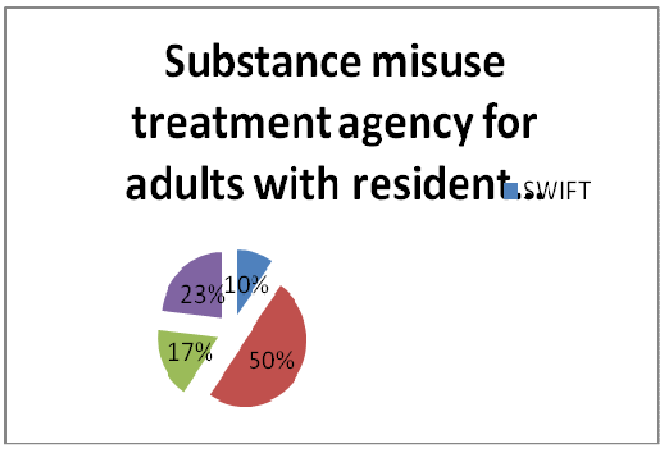
Parental substance misuse issues, including misuse of alcohol and other legal substances, is a significant risk factor in relation to children's wellbeing, and a potential indicator of the need for Early Help and Child Protection services.

National research estimates that there are 250–350,000 dependent children living with parental drug misuse [29] and 920,000 living with parental alcohol misuse [30] in the UK. If these estimates are applied to the East Sussex population on an equal share of the population this points to a potential for up to 7,000 children living with parental alcohol misuse and 2-2,500 living with parental drug misuse in East Sussex.

Graph 24 : Parental status of substance misuse clients



Graph 25: Substance misuse treatment agency for adults with resident



Adults receiving treatment for substance misuse issues in East Sussex are asked to identify if they have children, and if so whether they live with them or with others – for example a previous partner, another family member, Local Authority care, or independently. In the financial year 2012-13, 50% of adult substance misuse clients reported having children, and 20% identified that they lived with all or some of their children – 537 clients overall. The total number of children in the home is not identified from these data.

Of these 537 clients more than 50% were receiving treatment from Action for Change, commissioned to provide the specialist alcohol misuse service in East Sussex at that point. 10% were receiving treatment from the SWIFT specialist team hosted within the Children's Services Department, which provides a specialist multi-agency response for children and young people on a Child Protection Plan that combines adult treatment with a specialist

[29] Advisory Council on the Misuse of Drugs, 2003
[30] Alcohol Concern 2000

safeguarding response. The remaining 40% were receiving treatment from the Community Substance Misuse Teams.

In the same period, 2012-13, 9.3% of children placed on Child Protection Plans were identified as having alcohol abuse as a primary parental/carer risk factor, and 5% were identified as having drug misuse as a primary risk factor. This data is limited as CP Advisers are unable to record multiple risk factors, which we can establish from the family assessment reporting below and previous child protection needs assessment, should be considered in assessing the profile of this cohort.

Children's social care during 1st April to 10th December 2013 recorded parental risk factors as presenting in the social workers analysis, reported within the family assessment. The workers were able to report multiple risk factors. The information was recorded via the Care First information system and demonstrates reporting by geographical and the specification of the social care team.

Table 22: Children's social care during 1st April to 10th December 2013 recorded parental risk factors

Team Name	Child Drug Misuse	Child Alcohol Misuse	Parent Drug Misuse	Parent Alcohol Misuse
DAT - East	3.07%	3.40%	11.65%	13.75%
DAT - West	3.10%	2.85%	14.76%	15.51%
FST - Central			34.69%	38.78%
FST - Eastbourne North			45.71%	42.86%
FST - Eastbourne South			9.52%	14.29%
FST - Hastings			40.38%	36.54%
FST - Lewes			4.76%	9.52%
FST - Rother			46.15%	34.62%
FST - St Leonards North			37.04%	48.15%
FST - St Leonards South			29.73%	37.84%
FST - Wealden			17.91%	25.37%
YST - Eastbourne	3.91%	5.47%	0.78%	2.34%
YST - Lewes And Wealden	15.00%	14.50%	3.50%	16.50%
YST East	15.06%	4.25%	7.72%	5.79%

The Duty and Assessment Team's (DAT), intake team for CS social care reporting, is near identical on the table above, which suggests that they are collecting the information in the same way. However, the Family Support Team's (FST) recording of child use was hugely varied and it appears that respondents were utilising a different rationale when recording child's use, so we have deleted the data set from FST reporting. The Youth Support Teams varied activity levels is most likely to have been influence by workforce related circumstances and Lewes/Wealden is more likely to be an accurate record of presentations during this period.

This graph shows FST Rother as having a higher percentage of children being assessed with alcohol misuse as a risk factor than the parents. When you compare the "yes" respondents of the child's alcohol and drug misuse as a grand total to the parents, they average 46%. So on average, 46% of all the "yes" respondents of the parents grand total has been recorded as the child's.(With the exception of YSTs where the child's drug or alcohol misuses equals or exceeds the parents which is to be expected considering the age group that they deal with). The DATs are near identical on this graph which suggests they are collecting this information in the same way. The FSTs are all varied which suggests to us that they are not collecting this information in the same way as each other.

Table 23: Family assessments completed since April 2013 with substance misuse as an identified

Identified risk	Total	%
Alcohol Misuse child	146	6.2%
Drug Misuse child	167	7.1%
Alcohol Misuse parent	372	15.9%
Drug Misuse Parent	321	13.7%
Alcohol Misuse other	93	4.0%
Drug Misuse other	94	4.0%
TOTAL	**1193**	50.9%

The below data set relates to family assessments undertaken since 2013 where drug and alcohol use features as a parental risk factor. There were a total of 2,346 assessments reporting during this period. We can see that 50% of the families assessed by social care in 2013/14 are affected by parental/carer or child substance misuse. The data regarding children requires further analysis within FST as to the rationale of the social workers recording.

The overall trend of this graph shows that domestic violence and mental health are the most frequently recorded concern. However, if you were to combine drugs and alcohol reporting within the Family Support and Duty intake teams this would shift the risk reporting of substance misuse to the most common domain.

Table 24: Comparative reporting of thematic parental risk factors: Domestic Abuse/mental health/drug and alcohol misuse

Team Name	Parent Domestic Violence	Parent Mental Health	Parent Drug Misuse	Parent Alcohol Misuse
DAT - East	21.52%	23.79%	11.65%	13.75%
DAT - West	23.82%	22.46%	14.76%	15.51%
FST - Central	55.10%	46.94%	34.69%	38.78%
FST - Eastbourne North	57.14%	42.86%	45.71%	42.86%
FST - Eastbourne South	52.38%	71.43%	9.52%	14.29%
FST - Hastings	55.77%	46.15%	40.38%	36.54%
FST - Lewes	47.62%	42.86%	4.76%	9.52%
FST - Rother	34.62%	46.15%	46.15%	34.62%
FST - St Leonards North	62.96%	62.96%	37.04%	48.15%
FST - St Leonards South	62.16%	54.05%	29.73%	37.84%
FST - Wealden	38.81%	41.79%	17.91%	25.37%
YST - Eastbourne	10.16%	13.28%	0.78%	2.34%
YST - Lewes And Wealden	14.00%	21.00%	3.50%	16.50%
YST East	8.49%	14.67%	7.72%	5.79%

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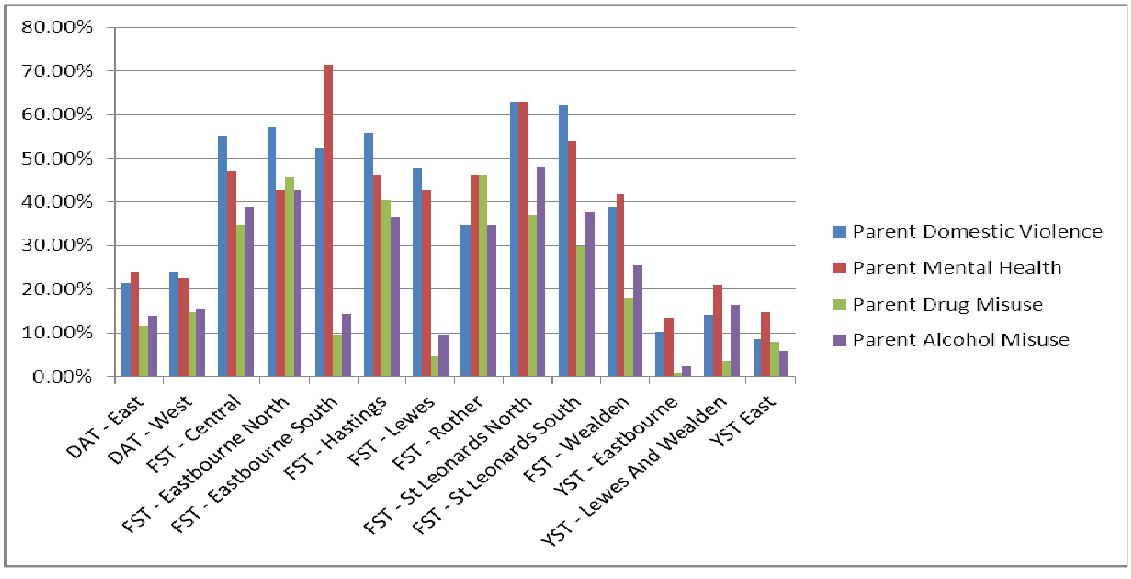
Graph 26: Comparative reporting of thematic parental risk factors: Domestic Abuse/mental health/drug and alcohol misuse



An East Sussex duty team analysis has been undertaken which investigates all initial contacts to the Duty and Assessment team from 1st April 2012 to March 31st 2013. However, in this case only one risk factor can be recorded by the intake worker.

Table 25: Initial contacts 2012/13 with drugs or addiction as the presenting issue

Count of Person's ID	
Contact Issue	Total
(C&F) Alcoholic Parents	288
(C&F) Drug taking Parents	418
(C&F) Drug/Substance Misuse - Child/Young Person	86
Grand Total	**792**

Once the relevant information is gathered and analysed the following referrals were processed to investigation or assessment. Again only one risk factor can be recorded.

Table 26: Referral - current rolling year only (2013) with drugs or addiction as the presenting issue

Presenting Issue	Total
(C&F) Alcoholic Parents	26
(C&F) Drug taking Parents	66
(C&F) Drug/Substance Misuse - Child/Young Person	26
Grand Total	**118**

During the same time period, there is a significant reporting difference between the initial contact primary risk and that identified by the screening team following an information analysis. However, in cases that escalate to a family assessment, where a social worker can record multiple risk factors, the risks pertaining to drugs and alcohol escalates to 50% of the social care report. Drug and alcohol misuse becomes a far more significant risk factor, following multiple risk recording and a more detailed assessment report. We have requested that a change in reporting is considered by the duty intake team to address the differential in reporting.

32.1. The number of people in drug treatment who are living with children

This section considers how well the drug treatment system engages families in treatment.

The National Treatment Agency publishes the 'Diagnostic Outcome Measures Executive Summary', which includes rolling twelve-month data about the people in treatment. Latest available data is reported in the table below.

Table 27: DOMES 2012/13 Q2 'Rolling 12 month' treatment data

EAST SUSSEX	**Number in treatment**	**Number (and %) living with children**
Opiate users	1065	278 (26.1%)
Users of other drugs	223	49 (22.0%)

This tells us that about 1 in 4 people who are receiving treatment for drug misuse in East Sussex are living with children. This is similar to the national picture. The proportion is similar across the populations using opiates, and other drugs.

The ‘in treatment’ population includes people who have recently started, and people who are stable and have been in treatment for several years. The National Drug Treatment Monitoring System quarterly performance reports provide comparative information about ‘new presentations’ in the current year – people who have started treatment since 1 April 2012. Latest available data is reported in table 2.

Table 28: NDTMS 2012/13 Q2 quarterly regional performance report ‘Year to Date’

New presentations – number and percentage with children: 2012/13 Q1	
East Sussex	41 / 204 : 20%
South East	792 / 3955 : 20%
England	9030 / 34490 : 26%

This tells us that the people who have started treatment since April 2013 are slightly less likely to be parents than the whole population, who are in treatment, but the numbers are relatively low and so this may change during the year. The proportion of people who are living with children is slightly lower than the national picture but in line with the average across the South East.

The Drug Treatment Monitoring Unit (DTMU) publishes annual reports that compare partnership profiles across the South East. Relevant treatment data for 2010/11 (published September 2012) is reported in the table below.

		Indicator	Local Number	Local Value	% Data Blank	SE Average	SE Lowest	South East Range	SE Highest
Demographics	1	IMD score	n/a	20.2	n/a	14.8	5.5		26.0
	2	Female clients	380	29.4	0.0%	27.6	21.9		31.5
	3	BME clients	58	4.5	1.2%	7.1	2.0		32.9
	4	Aged 18-24	130	10.1	0.0%	13.0	5.8		23.2
	5	Aged 50+	166	12.8	0.0%	7.3	2.1		12.8
	6	Client has children or is pregnant	688	53.2	0.0%	52.6	44.9		65.6
	7	At least one child living with client	288	22.3	0.8%	21.7	12.7		31.4

East Sussex is successfully engaging clients with children into treatment. Compared to other partnerships in the South East, East Sussex has the highest proportion of female clients. More than half of all clients are parents, or are pregnant. 1 in 4 clients has at least one child living with them. All of these indicators are within the upper quartile of indicators for South East partnerships.

32.2. Age of children

Access to financial help with childcare costs is likely to be a particular issue for families where there is a single parent and where the youngest child or children are too young to be eligible for free education.

In East Sussex, one in three of the parents who access treatment and are living with children have children who are too young to have started primary school. 1 in 5 has a child aged less than 3. Parents of younger children are engaging in services.

Information about the ages of the children who are living with clients is collected at assessment and recorded using Nebula, but not routinely reported. The information is not as complete as other areas of the patient record and not all records have a full name or date of birth. Records without a name or date of birth cannot be reported.

A report has been created that looks at records for clients with a Parental Status of ‘Some’ or ‘All of the children living with’ at 31 October 2012.

For the whole treatment population, there were 301 clients with at least one child living with them. 52 client records (17.3%) did not include a full date of birth for the child(ren), and these records were discarded. 106 (35.2%) of these clients had at least one child born after 31 August 2007, i.e. below the age of primary school reception. 67 (22.3%) of these clients had at least one child aged less than 3 on 1 September 2012.

For clients assessed in the previous twelve months, there were 147 clients with at least one child living with them. 38 client records (25.9%) did not include a full date of birth for the child(ren), and these records were discarded. 48 (32.7%) of these clients had at least one child born after 31 August 2007, i.e. below the age of primary school reception. 27 (18.4%) of these clients had at least one child aged less than 3 on 1 September 2012.

In Hidden Harm (2003), the Advisory Council on the Misuse of Drugs recommended that all social services departments should ensure "A co-ordinated range of resources capable of providing real support to families with drug problems, directed both at assisting parents and protecting and helping children." Help for parents and families with substance misuse issues are integrated in mainstream services.

32.3. Children's Centres

East Sussex Children's Centres aim to give the best possible start in life for children aged 0-5 years, and make it easier for families to use a range of important services, including childcare.

In some circumstances, short-term childcare bursaries are available for help with childcare:

- The child must be between the ages of 3 months and 5 years.
- The child must be referred to the bursary scheme by the Good Start Service, Social Worker and other partner agencies.

The child (or family) must either be:

- In a crisis situation such as bereavement where it is believed that some childcare sessions would alleviate the situation.
- At risk of significant developmental delay.
- Needing to attend a series of appointments in wider support of the child, such as Drug or Alcohol treatment.

In the last financial year, several families have been supported by the bursary scheme where substance misuse was identified as the main issue facing the family.

32.4. 2 year-olds

East Sussex County Council provides funded childcare places for families for up to 15 hours per week.

32.4.1. Band A

Children must be resident in East Sussex and parent/carer must be in receipt of one of the following benefits:

- claiming an eligible benefit (Income Support, Income related Job Seekers Allowance, Income related Employment and Support Allowance, Child Tax Credit if not entitled to Working Tax Credit and annual income is less than £16,191,Guaranteed element of the State Pension Credit, or support under Part VI of the Immigration and Asylum Act 1999)

The child must also be one of the following:

- on a Safeguarding/CP plan, on a Family Support plan, LAC (Looked after child) with additional needs, GRT (Gypsy Roma Traveller) family
- Referred via FNP (Family Nurse Partnership),
- Referred via TAF ("Team around the Family" a multi-agency early help planning meeting) and confirmed as Level 3 on the Continuum of Need. It is within this referral group that parents in drug and alcohol treatment that are not receiving existing CS would be eligible to access early help services.

For families who meet the criteria, the referral form needs to be completed.
Children identified as Band 'A' are eligible for an enhanced rate for the place to support the provider to provide help with any additional needs.

Of note, there is no longer a requirement to send copies of CAFSs/Early Learning Plans/Birth Certificates etc.

32.4.2. Band B – (self-referral)

Children must be resident in East Sussex and parent/carer must be in receipt of one of the following benefits:

- claiming an eligible benefit (Income Support, Income related Job Seekers Allowance, Income related Employment and Support Allowance, Child Tax Credit if not entitled to Working Tax Credit and annual income is less than £16,191,Guaranteed element of the State Pension Credit, or support under Part VI of the Immigration and Asylum Act 1999).

If you are working with a family who would benefit from 2 year old funding, signpost to the online application from at: www.eastsussex.gov.uk/childcare

The current database for this scheme holds referrals from 440 children - these include all children who have been age-eligible for 2 year funding in the financial year 2012-13. Out of these 440 referrals, 49 were listed as 'chaotic substance/alcohol misuse' as per below:

- Eastbourne - 15 families
- Hastings and St Leonards - 16 families
- Lewes - 10 families
- Rother - 4 families
- Wealden - 4 families

The availability of the scheme is being increased. Approximately 1,100 children are expected to accessing the scheme in September 2013, and 2,200 by September 2014. That will be about 40% of 2 year olds in East Sussex. The majority of those places will be determined by the same criteria used by schools for free school meals.

32.5. 3 and 4 year-olds

All 3 and 4 year-olds are entitled to 15 hours of free early education each week for 38 weeks of the year (Early Years Educational Entitlement). A child becomes eligible from 1 September, 1 January or 1 April following their 3rd birthday.

The free early education can be at nursery schools, children's centres, day nurseries, playgroups and pre-school, child minders or Sure Start Children's Centres. [31]

[31] http://www.eastsussex.gov.uk/educationandlearning/schools/financialhelp/nurserygrants/default.htm

32.6. Financial help from the community substance misuse team

The Sussex Partnership Foundation NHS Trust / CRI community substance misuse team manages a 'direct payments' fund that provides discretionary help to people who are engaging in treatment. The purpose is to provide extra help that supports recovery outcomes. The fund provides up to £20,000 of help each year as direct payments to East Sussex service users. If other sources of funding had been exhausted and paying for childcare was a barrier to treatment then applying for a direct payment would be considered appropriate. This source of help is available through care coordinators.

32.7. Access to free childcare in East Sussex

The information about access to treatment by parents who are living with children below the age of automatic eligibility to free education suggests not. A reasonable proportion of the people who start treatment are in this situation. The discretionary support available is being accessed by people with a substance misuse issue. The number of requests for help by parents of children aged less than two is low.

However, some families have identified access to childcare as a barrier. This has been raised as an issue through the East Sussex Recovery Alliance.

The other issue that was highlighted as part of this problem is that parents can be anxious about accessing services. They may be concerned about how Children's Services will respond. The National Treatment Agency (NTA, 2010) has reported that 'drug workers' often report female users' concerns about their children being 'taken into care' as a barrier to treatment. It is the concern about the impact of being identified as someone with a substance misuse problem that is the barrier, rather than a lack of help to access childcare.

Clearly, if a parent might benefit from treatment and their concerns about either stigma or childcare costs are a barrier then more could be done to address these issues. Matching services to clients needs improves treatment outcomes. The focus of this paper has been about ensuring those parents can access existing services, rather than establishing new childcare facilities in specialist services, or new services specifically for parents.

Some of the developments already identified above are likely to further improve access for parents with substance misuse treatment needs, for example:

- Increased availability of funded early years education for 2 year olds
- Development of the Family Keywork Programme

Other actions that are being taken to address these issues include:

- Information about the ages of children should be routinely recorded. The report highlights gaps in the data that will be addressed with providers.
- One of the Children's Centres coordinators has attended the Treatment Performance Group to communicate the Children's Centres offer to services and ESRA members. Information has been distributed to all treatment Performance Group members.
- Further meetings between ESRA members and local Children's Centre community development workers have been offered to explore how more parents with childcare needs can be supported.

32.8. Adult substance misuse community services

Adult substance misuse community services (drug and alcohol recovery services) were re-commissioned during 2013. The new specification requires providers to make available targeted interventions designed for adults who are parents, and whole family interventions where this is appropriate.

In addition the specification requires particular responses to ensure children's safeguarding – for example mandatory home visiting for treatment clients who have resident children, and assessment of those with caring responsibilities including young carers. The successful provider will provide group work programmes specifically designed to improve family functioning, and a designated family intervention lead for each area will be responsible for integrating family interventions within treatment plans. They have outlined plans for equipping staff to make appropriate onward referrals where appropriate both to Early Help and Social Care services.

32.9. SWIFT Service Overview

Within the context of safeguarding family services, the joint commissioned SWIFT Specialist Family Service hosted within the Children's Services Department but with external governance arrangements, provides specialist substance misuse treatment for adults whose children are subject to statutory safeguarding referral. This includes the delivery of assessment and low threshold interventions for families where parents do not require specialist treatment but are at risk of escalating misuse and whose children would be at subsequent harm. The service offer includes the delivery of Local Safeguarding Children Board training regarding the impact of parental substance misuse.

The service provides a treatment delivery and care coordination function for those parents whose substance misuse places themselves and their children at significant risk of harm. In 2013/14 the service specification was extended to meet the requirements of the Family Justice Review and now provides an expert assessment function for the local Family Justice Courts where parental drug/alcohol misuse is an identified risk factor in care proceedings.

Table 29: In treatment with SWIFT from 1st April 2013 – 31st December 2013

Tier 2	16
Tier 3	103
Total	**119**

The service has managed to engage service users in treatment, particularly female parents, at times when the risks of non-engagement with treatment providers or continued chaotic drug/alcohol use has been assessed to be detrimental to their ability to protect their children from harm.

32.10. Discharge findings

82.4% of discharges from SWIFT were completed in a planned way, with the majority being alcohol free. There were 7 clients who dropped out.

Table 30: Discharge reason

	Number	%
Treatment complete - drug free	11	21.6%
Treatment complete - alcohol free	18	35.3%
Treatment complete - occasional user (not heroin or crack)	13	25.5%
Transferred not in custody	1	2.0%
Incomplete dropped out	7	13.7%
Incomplete - treatment withdrawn by provider	1	2.0%
Total	**51**	**100.0%**

The NDTMS activity report is one element of the service specification with Children's Services commissioning to include a specialist assessment function as part of the Public Law

Outline pre proceedings implementation and/or an expert assessor role for the local Family Justice Court.

Activity in 2013/14, reflects the new commissioned offer, with SWIFT SMS.

Table 31:

Activity Type	Qtr 1	Qtr 2	Qtr 3
Families receiving a service	90	122	140
New Assessments	28	39	39
In proceedings assessments completed	17	7	3
New Interventions	18	31	21
External Consultations	19	13	21
Discharges	41	27	35
Interventions Timescales	163	184	200

32.11. Family Keyworking

The SWIFT service also hosts Family Keyworker roles that work alongside other Children's Social Care teams that will be responding to substance misuse needs in families. The Family Keyworker will act as a single point of contact for the family, providing direct support and coordinating additional interventions from a range of services.

Families must meet two out of the three main criteria:

- One member or more involved in crime / anti-social behaviour
- One member or more missing education through exclusions or unauthorised absence
- One adult or more in receipt of out-of-work benefits

The Family Keywork Programme is increasing the support available for some of the most vulnerable families in East Sussex. The Family Keyworker would be expected to identify and address any additional help that is needed to access childcare in order to engage with services.

The below report relates to the multi-agency Troubled Families commissioned Family Key Work delivery in 2013/14. The criteria for referral for a Family Key Work service are defined by government guidance and incorporate the headings worklessness, school attendance and anti-social behaviour.

Table 32: Multi-agency Troubled Families commissioned Family Key Work delivery in 2013/14.

Issue (Multiple reports)	Issue				Improvement			
	No issue	Low level	Significant	N/A	No improvement	Limited	Significant	Some improvement
Poor parenting skills	23%	32%	45%	25%	12%	38%	26%	63%
Safeguarding	39%	30%	31%	42%	13%	20%	25%	44%
Poor Behaviour in school	42%	19%	39%	42%	9%	19%	30%	49%
Financial problems	35%	39%	26%	38%	20%	28%	14%	42%
Risk of homelessness	74%	10%	16%	73%	6%	10%	11%	20%
Domestic abuse	65%	20%	15%	66%	8%	13%	13%	26%
Mental health problems	44%	28%	28%	47%	10%	26%	17%	43%
Drug / substance misuse	63%	20%	17%	66%	11%	12%	10%	22%
Alcohol misuse	69%	11%	20%	69%	8%	15%	7%	22%
Physical health issues	62%	18%	20%	64%	14%	15%	8%	23%

At lower levels of need and risk, the range of targeted Early Help services available in East Sussex described in Part 3 of this needs assessment are commissioned and specified to provide family support where substance misuse may be a factor in family functioning and

appropriate safeguarding of children and young people, but where needs do not require a Child Protection response. They utilise a range of interventions including Motivational Interviewing, Solution-focused approaches, and Information and Brief Advice in relation to these issues, supported by a workforce development offer to ensure skills are sufficient in this area.

Dialogue is ongoing between the Children's Services Department and adult substance misuse commissioners regarding further client data matching or data collection to identify the proportion of those in treatment that are receiving an early help family support service or Children's Social Care support.