

Developing Recovery Communities

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CONSULTATION QUESTIONS

This commissioning strategy has been prepared to share ideas about local priorities for the services that help people to recover from the misuse of drugs and alcohol. The ideas are set out in the following pages, along with some questions. The document has been published to consult with local people. If you would like to respond, please send your thoughts about the commissioning strategy to:

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The consultation will close 12 weeks after this paper has been published. Your response should arrive no later than 19 September 2011.

The consultation questions are summarised below:

- Q1 What do you think about the DAAT's vision for local substance misuse treatment?
- Q2 Local strategies and research: Are there other published strategies or research that should be considered?
- Q3 Do you have any comments about the accuracy of the information or analysis in the 'information and analysis' section?
- Q4 What other evidence is there about future demand for help with drug or alcohol problems?
- Q5 Local services: Are there other services that should be included in this section?
- Q6 Gap analysis: Are there other gaps that can be identified from the information and analysis, or other evidence?
- Q7 **Commissioning for outcomes and moving towards a focus on results:** Drawing on the earlier gap analysis, are these the right priorities for commissioners?
- Q8 **Maintaining and improving access to treatment:** Drawing on the earlier gap analysis, are these the right priorities for commissioners?
- Q9 **Delivering recovery and progress within treatment:** Drawing on the earlier gap analysis, are these the right priorities for commissioners?
- Q10 **Achieving outcomes and successful completions:** Drawing on the earlier gap analysis, are these the right priorities for commissioners?

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Executive Summary

1. The East Sussex Drug and Alcohol Action Team (DAAT) is the multi-agency partnership in East Sussex that addresses local drug and alcohol issues. Led by East Sussex County Council (ESCC), the DAAT includes local NHS organisations, District and Borough Councils, Sussex Police, Sussex Probation, HMP Lewes, Job Centre Plus, East Sussex Fire and Rescue Service and providers and users of services. The DAAT involves stakeholders through special interest groups. The membership of the DAAT will evolve over the course of the strategy and reflect the changes and to local statutory agencies, new clinical commissioning groups and public health.
2. This document focuses on what's needed in East Sussex to help more people recover from drug and alcohol misuse. It describes what is known about the local situation, identifies gaps and proposes how agencies will work together. This version of the document has been prepared for consultation, to test out ideas and find out more about local priorities.
3. National strategies are refocusing drug and alcohol treatment towards 'recovery'. The emphasis is on enabling people to complete treatment, free from dependence on drugs or alcohol.
4. Previous strategies have achieved significant successes. More people are seeking help for drug and alcohol misuse. Treatment services have become more efficient and treatment is more effective. Much more help is available for offenders at HMP Lewes. Links between drug treatment and the police are identifying the people whose drug use is linked to offending behaviour more quickly, and getting them the help they need.
5. Now that services are more available, the focus for drug and alcohol treatment has shifted towards 'recovery' from substance misuse. The commissioning strategy focuses on results. The aim is to continue to help more people access effective treatment, and help more people to recover. The priorities are set out in detail in the 'commissioning intentions' section. The strategy will expand access to treatment for users of different drugs. Services will target different groups of users, and be more visible in rural communities. If the 'test on arrest' service works well in Hastings and Rother it may be extended across East Sussex.
6. The partnership will focus on developing 'recovery communities' by developing peer support and encouraging more peer-led activities beyond treatment. Help with housing and employment will be integrated with drug and alcohol treatment, with extra help for those that need it.
7. The strategy will be underpinned by good quality information about treatment outcomes. Financial incentives will form an increasing proportion of the payment to the organisations that provide these services, as a 'Payment by Results' approach influences how services are purchased.
8. In a changing environment and driven by a new national service framework that focuses on building recovery in communities, this strategy sets out how the DAAT intends to help more people benefit from effective treatment for drug and alcohol misuse.

01 ► Introduction

9. The East Sussex Drug and Alcohol Action Team (DAAT) is the multi-agency partnership in East Sussex that addresses local drug and alcohol issues. The DAAT includes NHS Hastings and Rother, NHS East Sussex Downs and Weald, East Sussex County Council (ESCC), District and Borough Councils, Sussex Police, Sussex Probation, HMP Lewes, Job Centre Plus and providers and users of services. The DAAT involves stakeholders through special interest groups.
10. The DAAT published health and social care commissioning strategies for drug and alcohol misuse (2008-2011) in April 2008. Those strategies have informed the DAAT's annual plans to improve drug and alcohol treatment in East Sussex. This new strategy builds on the progress achieved and set out the DAAT's ambitions for improvement from April 2011 to March 2014.
11. The emphasis is on developing 'recovery capital', the internal and external resources that people draw on to initiate and sustain recovery. Achieving freedom from dependence on drugs or alcohol is critical, but only part of the story. People often need help to sort out practical issues like housing and employment, and develop new relationships with friends and family. We know that people value long-term support, provided through a 'recovery community' of others who have travelled similar journeys.
12. The strategy considers national and local policy. It considers what we know about local services and identifies gaps. It considers how we can align local services to support people's recovery from drug and alcohol misuse. The strategy concludes with recommendations to improve services and describes what the DAAT intends to achieve.

Translating the strategy into action

13. The strategy describes what the DAAT partnership wants to achieve. The commissioning intentions towards the end of the document describe how these aims will be achieved.
14. An annual 'treatment plan' will be developed each year to describe how the next priorities in the strategy will be implemented. Running from April to the following March, these plans will be agreed by the DAAT's Joint Commissioning Group, which will also be responsible for ensuring the plans are delivered. The annual plans will include both alcohol and drug misuse priorities. Drawing on the 'commissioning intentions', the plans will describe specific outcomes, a timetable for delivery, who will lead progress towards the outcomes and any 'milestones' that demonstrate progress along the way. The objectives within the treatment plans will be included in contracts with providers and DAAT partners' delivery plans, as appropriate.

Scope

15. This strategy addresses the needs of adults (people aged 18 and older). It focuses on health and social care interventions for people who are already affected by drug and alcohol misuse. It sets out local ambitions to reduce drug misuse and dependence on all controlled drugs, including prescription and over-the-counter (OTC) medicines. The strategy focuses particularly on the drugs that

cause the most harm - opiates and crack cocaine - and the people that use them. It sets out local ambitions to reduce alcohol misuse and dependence.

16. This strategy does not address the availability of drugs or alcohol, prevention programmes or the needs of children. These issues are addressed by other local strategies.
17. The strategy explicitly considers the needs of offenders. There are clear links between offending and the damage caused by alcohol and drug misuse. There is considerable overlap between the police, courts and prison and the health and social care services for people who misuse alcohol and controlled drugs.

The DAAT's vision for a local substance misuse recovery system

18. The DAAT's vision describes what a local recovery system for drug and alcohol misusers should look like:

“Local people who need help for drug or alcohol misuse can quickly access effective treatment services and recovery communities that are shaped by the people they support.”

19. “Quickly” means at least 95% of people can access treatment within three weeks – and most within a few days.
20. “Effective treatment” means that the performance of local services that help people to recover and live free from dependence on drugs or alcohol in a sustained way is consistently within the performance range of the top 25% of authorities in England.
21. “Recovery communities” means natural communities of people who have experienced substance misuse problems who support each other to achieve and maintain their recovery. This will include peer-led approaches, mutual aid and 12-step fellowships.
22. “Shaped” means ensuring that the views and experiences of local people who need help for drug or alcohol misuse are clearly linked to service design and the development of recovery communities.

Q1	What do you think about the DAAT's vision for local substance misuse treatment?
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National strategy and research

23. The White Paper ‘Healthy Lives, Healthy People’ (2010) describes how Public Health England should be responsible for funding and ensuring the provision of services that address drug and alcohol misuse. National indicators proposed in the Public Health Outcomes Framework consultation document include the rate of hospital admissions per 100,000 for alcohol related harm, and the number leaving drug treatment free of drug(s) of dependence.
24. HM Government (2011) ‘No Health Without Mental Health’ strategy describes the value of effective treatment for drug and alcohol misuse. Links between effective mental health, drug and alcohol services are a critical part of the strategy to improve health and wellbeing.

Drug Misuse

25. The Marmot Review (2010) includes “Increasing and improving the scale and quality of drug treatment programmes” as a policy recommendation (F2i). The intended outcomes of this policy are fewer problem drug users, less criminal activity and reduced adverse health outcomes of problem drug use and the social and economic cost of drug-related crime.
26. HM Government (2010b) national strategy “Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life” sets out the coalition government’s ambitions to address drug misuse. Previous strategies have focused on developing services to attract more people into effective treatment. The new strategy reaffirms the need to get people into treatment when they need it, and ensure they stay in long enough to overcome dependency and start rebuilding their lives. The strategy has a new emphasis on helping people to leave treatment safely and reintegrate into society.
27. Referring to the Coalition Government’s proposals for the NHS, the strategy describes the transfer of the core functions of the National Treatment Agency (NTA) to Public Health England from April 2013. With an emphasis on local leadership, the strategy notes that “Directors of Public Health will see commissioning and oversight of drug and alcohol treatment services as a core part of their work.” The Department of Health will publish the results of the consultation on the arrangements for public health later in 2011.
28. The ‘treatment’ aspects of the strategy put more responsibility on individuals to seek help and overcome dependency, and emphasise a holistic approach. The strategy describes how ‘recovery’ can be achieved by addressing offending, employment and housing as part of drug treatment, and making links between the ‘treatment community’ and the ‘recovery community’.
29. Under the working title of ‘Building Recovery in Communities’, The NTA is developing new guidance about the design of local services to replace Models of Care (2006). The strategy also introduces a ‘payment by results’ (PbR) framework which will provide incentives for achieving recovery outcomes. Drawing on an international evidence base, the NTA is developing ‘Patient Placement Criteria’, which will guide decisions about which sorts of interventions will work best with which sorts of patients. The new guidance and PbR approach will provide a national framework for local commissioning plans.

Alcohol Misuse

30. In ‘Signs for Improvement’, the Department of Health (2010) described ‘high impact’ changes and actions to reduce alcohol-related harm. These evidence-based recommendations focus on:
 - Working in partnership
 - Developing activities to control the impact of alcohol misuse in the community
 - Influencing change through advocacy
 - Improving the effectiveness and capacity of specialist treatment
 - Appointing an Alcohol Health Worker
 - Identification and Brief Advice (IBA) - providing more help to encourage people to drink less
 - Amplifying national social marketing priorities

31. All NHS organisations are required to implement the guidance that the National Institute for Health and Clinical Excellence (NICE) publishes. NICE has published a suite of guidelines that address 'alcohol use disorders'. The guidelines offer a comprehensive, evidence-based approach to addressing alcohol use disorders.
- [1] Preventing harmful drinking. (PH24, June 2010)
 - [2] Diagnosis and clinical management of alcohol-related physical complications. (CG100, June 2010)
 - [3] Management of alcohol dependence (CG115, February 2011)

Substance Misuse and Offenders

32. The report of the Prison Drug Strategy Review Group chaired by Lord Patel (2010) encourages national and local strategies for drug misuse that integrate the needs of drug misusing offenders. It describes how joined-up commissioning enables services to "...reduce re-offending and improve health and rehabilitation." The report proposes an outcome framework with four primary domains:
- Reduced drug use
 - Reduced re-offending
 - Improved health, social functioning and relationships
 - Increased employment and enhanced workforce skills
33. The Bradley Report (Department of Health, 2009) tells us that prisoners have significantly higher rates of mental health problems than the general public, and that the prevalence of 'dual diagnosis' drug and/or alcohol problems amongst offenders with mental health problems is high, and should be "...regarded as the norm, rather than the exception." The report includes two particularly relevant recommendations on criminal justice diversion, to improve 'dual diagnosis' services for prisoners urgently, and ensure joint care planning between mental health services and drug and alcohol services for people resettling from prison.
34. The Centre for Mental Health (Fitzpatrick and Thorne, 2010) highlights the importance of effective joint commissioning for alcohol misusing offenders, with implications for both health and criminal justice agencies. Effective alcohol interventions are needed at every step of the offender pathway. Alcohol Concern (2010) identifies the single biggest gap in alcohol service provision to be an adequate pathway from prison to community treatment for alcohol dependent offenders.

Local strategies and research

35. The strategy has been developed in the context of other local strategies and research including:
- Director of Public Health's 2010 Annual Report - Reducing Health Inequalities in East Sussex.
 - Alcohol Needs Assessment (2009)
 - Alcohol Harm Reduction Strategy (2009/12)
 - Drug Treatment Needs Assessment (2011)
 - Adult Reoffending and Integrated Offender Management Needs Assessment (2011)

- The Dual Diagnosis Strategy for Sussex Partnership NHS Foundation Trust (2011-2016)
36. The DAAT considers local drug treatment need in its annual needs assessment. The needs assessment includes benchmarking data to provide comparison to other areas. Outcome measures are drawn from the 'Treatment Outcomes Profile' which gathers information about the progress every person in treatment is making, every three months. This strategy draws on the needs assessment that the DAAT published in March 2011.
37. Alcohol Concern completed an alcohol needs assessment in 2009 ("Assessing and Addressing the Harms Caused by Alcohol to Individuals and Communities in East Sussex"), which ESCC and the local NHS included in the Joint Strategic needs Assessment (JSNA). Public Health has reported further updates about alcohol misuse annually.
38. The Health Protection Agency (2010) has established the importance of improving NSP coverage. The East Sussex Drug Harm Reduction Strategy (2010) describes the local plans to increase the volume of injecting equipment distributed. Those plans have been included in this strategy.

Q2	Are there other published strategies or research that should be considered?
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02 ► Information and analysis

39. This section summarises the key issues identified by the DAAT's needs assessments and performance data.
40. The population of East Sussex is skewed towards the older end of the age range, with just over half (51%) of the population being 45 and over, and just under a third of individuals (30%) being of a pensionable age. The white population accounts for 94.8% of the population. The remaining 5.2% of the population is made up of Asian or Asian British (1.6%), Mixed (1.3%), Black or Black British (1.2%) and Chinese or another ethnic group (1.1%).

Drug Misuse - Prevalence Estimates

41. Hay et al (2010) estimate that there are 2080 people aged 15 to 64 using opiates or crack cocaine ('Problem Drug Users') in East Sussex. This estimate has a 95% confidence interval of 1489 to 2716, meaning that there is a 95% certainty that the true value exists within the range 1489 to 2716, though it is more likely to lie near the estimate itself.
42. There are 149 'Drug Action Team' (DAT) partnerships in England, which broadly reflect upper-tier and unitary local authority boundaries. East Sussex has a relatively low estimated prevalence of heroin or crack cocaine use. The prevalence (6.7 PDUs per 1,000, shown at the red line below) is in the second quartile of all DATs. Prevalence is slightly lower in Kent (6.3 per 1,000), lower in West Sussex (4.9 per 1,000) and higher in Brighton (11.7 per thousand).

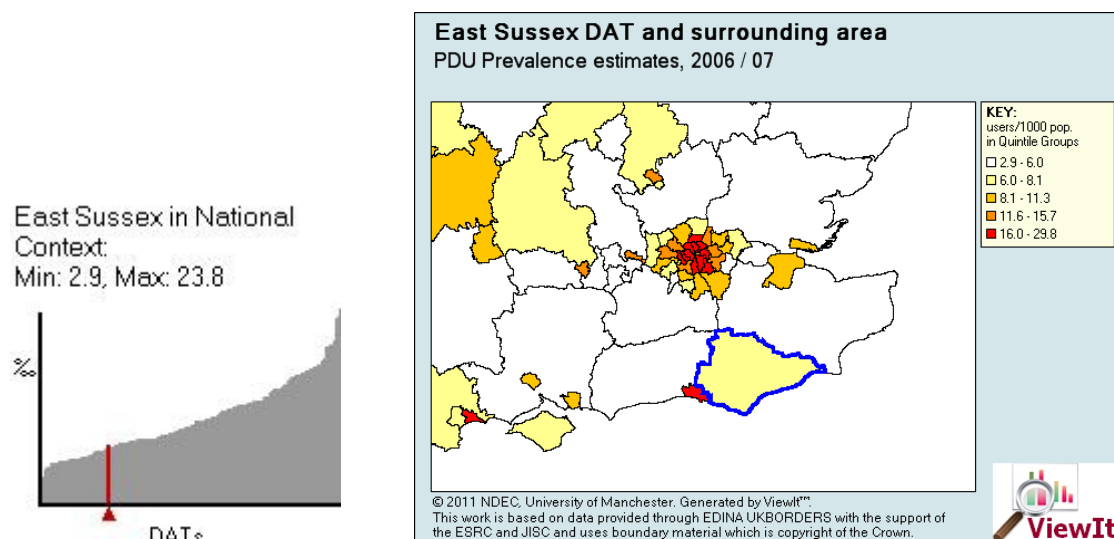


Figure 1: Prevalence of opiate and crack cocaine users - Source: NDTMS

Drug Misuse - Treatment Bulls Eye

43. The 'treatment bulls eye' compares the Hay (2010) estimate with information about treatment - the National Drug Treatment Monitoring System (NDTMS) and Drug Intervention Programme (DIP) data, plus any other available local data - to report the 'penetration' of drug treatment into the population of people using opiates or crack cocaine.

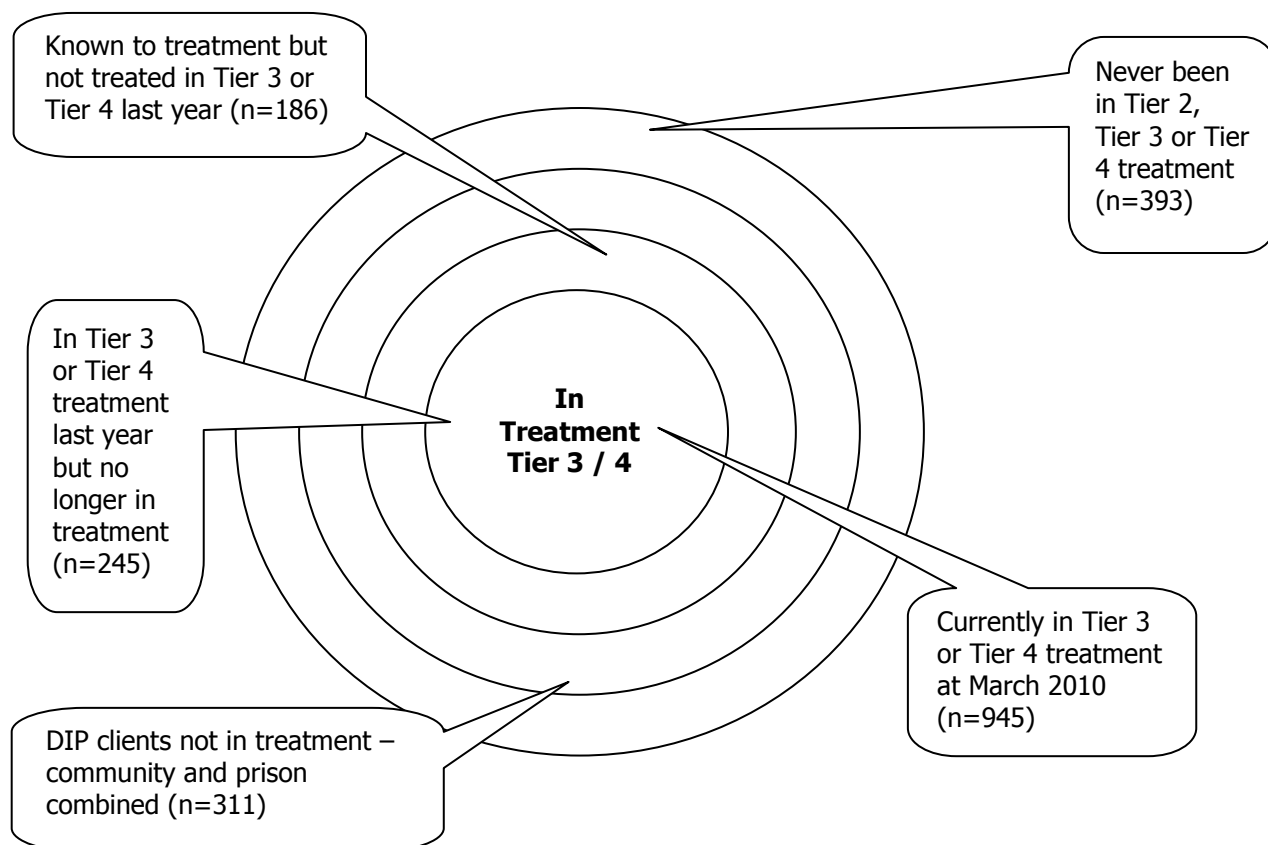


Figure 2: Treatment bulls eye - estimated PDU population - Source: NDTMS

44. This approach identifies 1,687 PDUs within the inner rings of the bulls eye (known to treatment). Treatment penetration – the proportion of estimated PDUs that are engaging with treatment - is approximately 80%. The approach estimates that there are 393 PDUs in East Sussex who have not accessed treatment, people who are ‘treatment naïve’.

Drug Misuse - Adults Who Access Treatment

45. The needs assessment estimates that approximately one third of the treatment naïve population (108 of the 393) are female, and 40% (N=155) are injecting drug users. 40% aged less than 35, just 15% (N=60) are aged less than 25. The needs assessment also describes the ‘treatment naïve’ population using the same age groups. This indicates that only 15.3% of the treatment naïve population, 60 people, are aged less than 24.
46. The needs assessment describes how the treatment system has consistently increased the number of adults engaged in effective treatment each year. By 1 January 2011, 1,278 adults (of whom, 1,151 were PDUs) had been engaged in effective treatment during the previous year. This was an increase of 25% since 1 April 2007.
47. We know from the needs assessment that the profile of people in treatment is similar to other areas in the South East, and England. Overall, two thirds are male. 53% are aged 30-44. When looking at gender differences, more women access treatment aged less than 30 (32.5% of all women) than men (20.5% of all men). The ethnic groups of the people in treatment reflect the local population.
48. As might be expected, many of the people in treatment live in the most deprived areas of East Sussex. The dark blue areas on the left map show the areas that have been categorised as the most deprived 10% in England. These areas are mainly situated in Eastbourne, Hastings and the Central Bexhill area of Rother. The dots in the map on the right represent clusters of people in treatment. 78% of the people in treatment live in Eastbourne or Hastings.

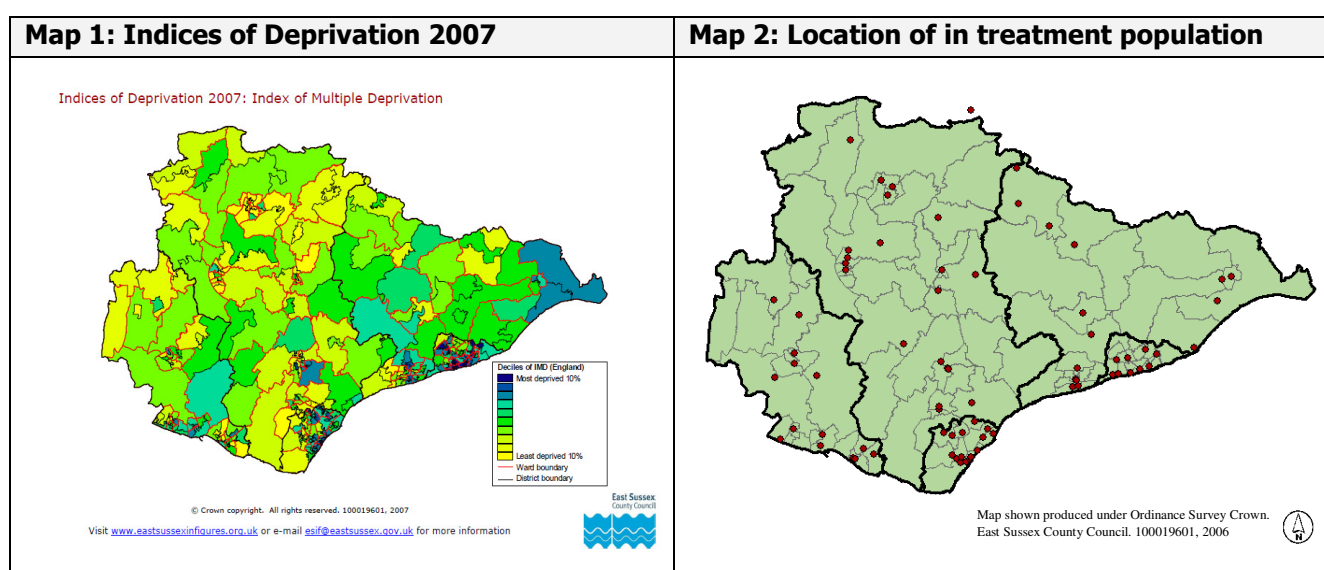


Figure 3: Deprivation and drug misusers in treatment.

Source: ESiF/NDTMS

49. Many people in treatment have multiple needs. 11.6% (N=161) have reported that they were receiving treatment from mental health services (for reasons other than substance misuse).
50. Nearly one in five people (18.7%) who entered treatment during 2009/10 had an acute housing need. Progress was reviewed at approximately three months, and by then 10% had an acute housing need.
51. The majority of people who enter treatment aren't employed. Of the people that entered treatment during 2009/10, 16.3% (N=73) were employed, and a little over half (N=41, or 56.2%) of those were employed full-time. This level of employment is lower than average for people accessing drug treatment across the South East.
52. Only 12% (N=170) of people in treatment reported they were in regular employment. 48% (N=666) reported they were unemployed, and a further 14% (N=195) stated they were unemployed and seeking work. 2% (N=25) said they were unable to work through long term sickness or disability.
53. The needs assessment reports that men aged 30-44 were the group most likely to present to treatment with both an employment and a housing need.
54. 22% (N=302) of the individuals have either all or some of their children living with them, 422 (30%) have children who live elsewhere including with a partner or with other family members.
55. Most of the people who were in treatment during 2009/10 describe heroin (73.7%, N=1023) or crack cocaine as their primary drug of choice. Crack use was reported by 28.8% (N=400).
56. 56% of people in treatment declaring heroin use were aged 30–44, more than for other age groups. Over half (53.7%) of those reporting cocaine as their primary substance were aged 18 to 29. 88.2% of those declaring Crack as their main substance were in the 18 to 44 age group, which is slightly higher than previous findings when 71% were aged between 20 and 40.
57. Information about drug related deaths is considered in detail in annual Confidential Inquiries into drug related deaths in East Sussex. The most recent report was published in June 2010. Although the number of deaths each year is relatively low (21 in 2009), the number has increased since the first Confidential Inquiry in 2004 (when there were 15 deaths).
58. Implementing national strategy, local services have been designed to particularly address the needs of people who use heroin and crack cocaine. There are no local estimates for the number of people using other drugs. There is good evidence that when services are able to engage these people into treatment they can be helped to achieve positive outcomes and leave treatment drug free.
59. The 'in treatment' population in East Sussex has a greater proportion of heroin users and injectors than the national average. Nearly half of the people who reported 'currently or previously' injecting when they entered treatment had shared injecting equipment with other users. Approximately 90% of hepatitis C infection is estimated to be transmitted by sharing injecting equipment. We know from the harm reduction strategy (2009) that local prevalence of hepatitis C is 40%-60%.

60. The 'coverage' of the needle and syringe programme has improved since the harm reduction strategy was published in 2010, from 35% to 54% of estimated injections of opiates or crack cocaine by December 2010. This is still significantly below the 100% minimum recommended by the National Institute for Health and Clinical Excellence (NICE).

Alcohol Misuse

61. We know from the alcohol needs assessment that East Sussex is part of a region which, despite having lower levels of hazardous and harmful drinking has significant numbers of dependent drinkers. Parts of the county have drinking patterns which are among the highest in the country.
62. The needs assessment estimates the number of people who are drinking at levels likely to cause harm, or already causing harm.

	Hazardous/Harmful 19%	Dependent 4%
Eastbourne	10,678	2,248
Hastings	10,250	2,158
Lewes	10,535	2,218
Rother	9,230	1,943
Wealden	16,283	3,428

Table 1: Estimated prevalence of dependent drinking

63. The Department of Health (2010) recommends that local partnerships should ensure the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the PCT area. The local NHS has an agreement with the Community Alcohol Team to provide specialist treatment, up to a maximum level of activity. That provision, and the uptake in the 12 months to 1 April 2011 is reported in the table below.

	Dependent population	15% of that population	Provision 2010/11	Activity to 31 March 2011
NHS Hastings and Rother	4,101	615	1,196	577
NHS East Sussex Downs and Weald	7,894	1,184	1,100	669
East Sussex	11,995	1,799	2,296	1,246

Table 2: Provision and uptake of alcohol treatment. Source: NDTMS

64. Across East Sussex as a whole, there is sufficient provision to meet this guideline – the 2,296 commissioned activity is 19% of the anticipated demand. However, the provision is unequal. NHS Hastings and Rother has better provision of this service than NHS East Sussex Downs and Weald (which has provision for 13.9% of the estimated dependent population).
65. Looking to activity, during the first year of the newly established service in East Sussex, around 1 in 10 of the estimated population of alcohol dependent adults in East Sussex entered treatment. A greater proportion of the estimated population entered treatment in NHS Hasting and Rother (14.1%, N=577) than in NHS East Sussex Downs and Weald (8.47%, N=669).

Alcohol Related Hospital Admissions

66. The nationally adopted measure for the impact of alcohol on the health service is the rate per 100,000 population of alcohol related hospital admissions. The measure draws on Hospital Episode Statistics (HES) to calculate the local (PCT) rate. The North West Public Health Observatory leads this work and publishes rates for each PCT.
67. The measure includes both chronic and acute conditions and the rate is considered to be sensitive to the impact of a number of prevention interventions. The key intervention is identification (screening) and brief advice, especially in primary care. There is an emerging evidence base that suggests that there is potential for marketing to influence middle-aged adults' drinking.
68. The rate of alcohol related hospital admissions is particularly valuable as a way of reporting long-term trend data about the impact of alcohol. The most recently published data shows that the rate of admission in 2009/10 in England was 1,743 per 100,000 population, up 10% on 2008/09. The rate in East Sussex was lower than this, and 2% lower than 2008/9, but higher than the South East.

	2008/09 Rate per 100,000	2009/10 Rate per 100,000	Difference
England	1,582	1,743	+10%
South East	1,235	1,335	+8%
East Sussex	1,471	1,448	-2%
NHS ESDW	1,432	1,418	-1%
NHS HR	1,548	1,506	-3%
Eastbourne	2,295	2,176	-5%
Hastings	1,816	1,763	-3%
Lewes	1,767	1,879	+6%
Rother	1,685	1,720	+2%
Wealden	2,646	2,649	-

Table 3: Alcohol related hospital admissions 2009/10 - Source: NWPHO

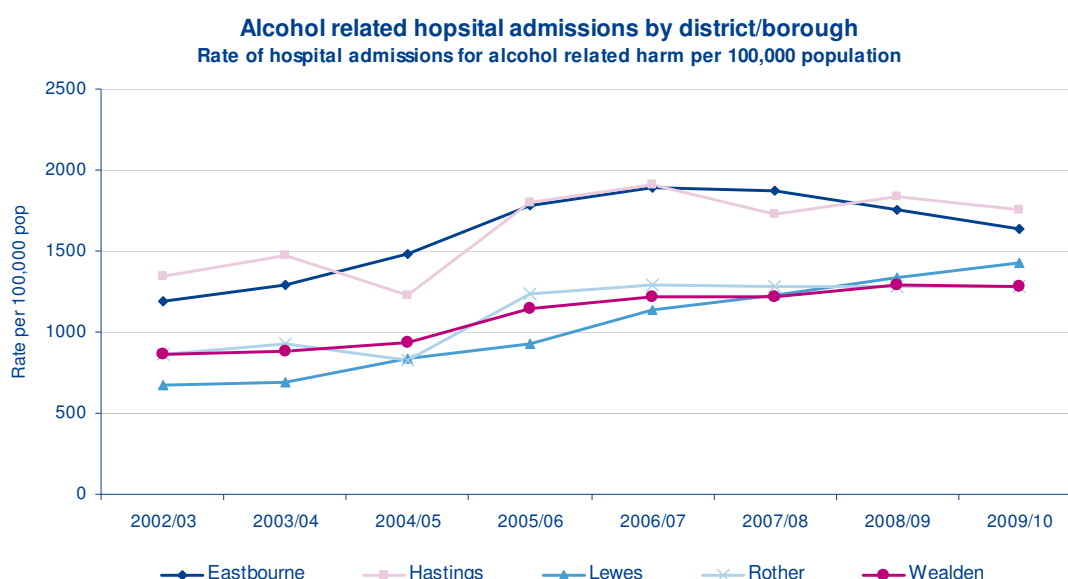


Figure 4: Alcohol related hospital admissions

Source: NWPHO

69. Comparing the rate across the two NHS Primary Care Trust organisations in East Sussex, the rate is broadly similar and reducing in both areas. Comparing the rate across district and borough councils shows a marked variation in both the rate of alcohol related hospital admissions, and the change since 2008/09. Unlike other areas in East Sussex where the rate of alcohol related hospital admissions reduced, the rate increased by 2% in Rother and by 6% in Lewes compared to the previous year.
70. The impact of alcohol is monitored closely by the partnership. Drawing on the evidence provided by NWPHO, the local public health department publishes this trend data alongside other evidence in June each year.
71. The most recently published summary Local Alcohol Profiles for England (LAPE) compares Local Authorities to England across a number of indicators and show:
 - Hastings, Lewes and Rother LAs as significantly worse in relation to alcohol-specific admissions for the under 18s
 - Hastings and Eastbourne are significantly worse in relation to hospital admissions for alcohol related harm (NI39) while Lewes, Rother and Wealden are significantly better and are in line with the regional average
 - Hastings is significantly worse in relation to alcohol related violent crime, alcohol related crime and alcohol related sexual offences

Substance Misuse And Offenders

72. The drug treatment needs assessment describes the situation locally with more heroin and crack users entering effective treatment, lower than anticipated drug related offending and an overall trend of reducing crime.
73. The local prison, HMP Lewes, is a Category B local prison for sentenced and remanded men with an operational capacity of 723. The East Sussex Director of Public Health's (2010) report tells us that "a high proportion of prisoners have drug problems. Of all new receptions to HMP Lewes last year (2009/10), 32.8% were assessed as needing treatment for substance misuse problems. Over a ten-month period, 228 inmates started treatment."
74. The Integrated Drug treatment System (IDTS) has been operational since April 2009, when access to prescribing interventions was increased, alongside the non-medical interventions provided by the Counselling, Advice, Referral, Assessment and Through-care (CARAT) team within the prison. Around 1 in 3 of the men received at HMP Lewes are identified as needing drug treatment, and 75% of those enter drug treatment at HMP Lewes.
75. The drug treatment needs assessment tells us that of the 14% (N=195) of people in treatment in the community in 2009/10 who were referred from the criminal justice system, almost half were referred by CARATs. The age profile of offenders in drug treatment is broadly similar to people who don't offend. There are proportionally more male offenders (77%, N=148).
76. People referred to treatment through criminal justice pathways (the police, courts or prisons) were significantly more likely to have an acute housing need. 33% of people referred to the Criminal Justice Integrated Team described themselves as either of No Fixed Abode and living on the streets or sleeping on a different friend's floor each night, or had a housing problem and were staying with friends or family as a short term guest or were living in a short stay hostel.

77. Unemployment is a common feature amongst offenders in drug treatment. 81% of people referred to the Criminal Justice Integrated Team were unemployed, and 59% of the people who engaged in treatment and were referred through the criminal justice system were unemployed.
78. Whilst the profile of drugs used by offenders in drug treatment is broadly similar to the whole treatment population, offenders are more likely to report use of crack cocaine.
79. In areas that are able to 'test on arrest', arrest for the offences associated with drug misuse leads to a drug test. Local investigation of crime types has identified many younger offenders, under 24, being arrested for drug related 'trigger' offences, which would trigger a drugs test in areas where testing is available. Plans are in hand to introduce testing in Hastings and Rother to identify and refer these people to treatment.
80. These 'trigger' offences tend to be most prevalent mid-week, and less prevalent at weekends. 18% (N=499) of the people committing these offences were arrested multiple times. During 2009/10, 84% of the people arrested for trigger offences were not receiving specialist drug treatment in East Sussex.

Co-morbid Mental Health And Substance Misuse Problems – 'Dual Diagnosis'

81. The Dual Diagnosis Strategy for Sussex Partnership NHS Foundation Trust notes that determining local prevalence of co-existing substance misuse and mental health problems is 'challenging'. Audits of local specialist mental health services suggest prevalence amongst people with severe mental health problems is comparable with published studies (9-20%). The prevalence of mental health problems amongst people entering substance misuse services is estimated to be higher, with 40%-90% of this population presenting with mental health issues - for example anxiety and depression.

Q3	Do you have any comments about the accuracy of the information or analysis in the 'information and analysis' section?
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Reviewing the impact of the previous (2008-2011) strategies

Drug Misuse

82. The 2008-2011 health and social care commissioning strategy for adult drug misusers described commissioning intentions to March 2011. The strategy has to a large extent been implemented. Community drug treatment services were market tested across East Sussex by December 2009. The 'Integrated Drug Treatment System' (IDTS) at HMP Lewes was 'live' from April 2009. There has been an increase in the resource allocated to inpatient detoxification, but the proposal to establish a 14-bed specialist unit serving all Sussex residents has not been realised.
83. An impact evaluation was completed twelve months after the introduction of the new community substance misuse teams (see Appendix Two). Across a range of indicators, the impact of this activity has been positive. More opiate and crack cocaine users are engaged in effective treatment, and leaving treatment drug free. The table below refers to the high-level indicators that were included in the previous strategy.

Measure	2007/08	2008/09	2009/10	2010/11
Problem drug users in effective treatment.	921 (baseline)	1070 (baseline +14.6%)	1124 (baseline +22%)	1162 (baseline +26.2%)
All adult drug users in effective treatment	1041 (baseline)	1249 (baseline +20%)	1257 (baseline +20.7%)	1299 (baseline +24.8%)
PDU in treatment for more than 12 weeks or planned discharge before then.	71%	85%	81% (4% more were transfers, which would have been 'retained' in previous years).	90% (3% more were transfers, not in custody)
Planned discharge	21% (N=196)	35% (N=113)	44% (N=149)	64% (N=241)

Table 4: Impact of previous drug misuse strategy - Source: NDTMS.net

84. Of the 2,080 estimated opiate and crack cocaine users in East Sussex, 55.9% (N=1,162) were engaged in effective treatment between 1 April 2010 and 31 March 2011.
85. At January 2011 the services had not yet fully realised the level of activity that was anticipated when the community services were market tested. Further development of 'shared care' services with primary care is still required to achieve the optimal balance described by the service provider.

Alcohol Misuse

86. The 2008-2011 health and social care commissioning strategy for adult alcohol misusers described commissioning intentions to March 2011. A significant part of the strategy has been implemented. The East Sussex PCTs have invested an additional £700K annually (£330K in Hastings and Rother and £370K in East Sussex Downs and Weald) to develop the Community Alcohol Team. The competitive tender for the service was completed by December 2009 and 'alcohol key workers' have been attached to GP surgeries across East Sussex since April 2010. Two staff provide a dedicated 'in-reach' service at HMP Lewes as part of the healthcare team. Treatment data is recorded using the combined drug and alcohol treatment data information system that the DAAT has procured and manages.
87. The East Sussex Primary Care Trusts approved the 'Local Enhanced Service' agreements described in the strategy for community alcohol detoxification in 2010/11. Rather than an 'alcohol arrest referral' service, staff from the Community Alcohol Team work alongside police officers and probation staff as part of the local 'Integrated Offender Management' teams. There has been an increase in the resource allocated to inpatient detoxification, but the plans to establish a 14-bed specialist unit have not been realised.

88. The health improvement interventions planned in the strategy were adapted to reflect the 'high impact changes' recommended by the Department of Health in 2009. Training for 'tier 1' staff has continued and focused on 'Identification and Brief Advice'. Communications activity around safer drinking has been coordinated. The 'alcohol intervention specialists' role described in the strategy and the 'training the trainers' programme were not developed.
89. The impact of this activity on the number of people accessing treatment has been positive. Significantly more people are seeking specialist help from the Community Alcohol Team about an alcohol problem. The 2009 alcohol needs assessment reported that East Sussex's total rate of referral for alcohol treatment was well below the national average and below directly comparable areas such as West Sussex and Oxfordshire.
90. By comparison, more recent 'treatment' data indicates that the rate in East Sussex is now above the rate for England and also exceeds the rate of the comparator areas selected for the 2009 needs assessment. The rate has been calculated using the same population estimates as in the original calculation and the number of people entering treatment for each PCT area reported by NDTMS.

	Pop'n	April 2008 – February 2009		April 2010 – March 2011	
	(,000)	Alcohol clients	Rate per 1,000 pop'n	Alcohol clients	Rate per 1,000 pop'n
East Sussex Downs and Weald		210		669	
Hastings and Rother		243		577	
East Sussex (combined PCTs)	506.2	453	0.89	1,246	2.46
Oxfordshire	632.0	651	1.03	768	1.22
West Sussex	770.8	1,151	1.49	1,027	1.33
England	50,762.9	98,058	1.93	116,194	2.29

Table 5: Alcohol treatment activity per 1,000 pop'n - Source:NDTMS.net

91. The table below reports progress with the 'milestones' that were included in the previous strategy.

Milestone	Comment
Local alcohol treatment pathways have been fully developed.	Achieved. The community alcohol team manages the care pathway from tier 2 to tier 4, and is integrated with primary care.
Alcohol screening & Brief intervention protocols are in place for Tier 1&2 interventions.	Partially achieved. IBA training targets primary care and other specified settings. The community alcohol team provides 'open access' tier 2 interventions. An audit using the NICE Public Health guideline 24 has identified a range of settings where practice can be improved.
A range of evidence based alcohol treatment interventions are available across East Sussex in an equitable way.	Achieved. The community alcohol team specification includes a range of evidence-based interventions.
Protocols for collaborative & integrated working are in place to meet the more complex needs of some clients.	Partially achieved.

Table 6: Impact of previous strategy: Treatment for alcohol misuse.

Future Demand for Services

92. Nationally, patterns of drug misuse are changing. HM Government (2010b) notes that fewer young people are becoming dependent on heroin. The NHS Information Centre (2009) reports that cocaine use has increased, whilst the use of other controlled drugs has remained the same or reduced.
93. The local drug treatment need assessment includes detailed information about local patterns of the misuse of heroin and crack cocaine. The indications are that the number of people using heroin will remain stable or reduce, and the number of people using cocaine will continue to rise.
94. HM Government (2010b) also refers to new psychoactive substances ('legal highs'), and the evidence that the use of these substances has been increasing. The substances are often amphetamine-type stimulants, with unknown short and long-term risks and adverse side effects.
95. For alcohol, there is evidence that overall consumption has been falling in England since 2002. Drawing on the General Household Survey, the Office of National Statistics (ONS, 2011) reports reductions in average weekly alcohol consumption for men and women since 2002. ONS also note that part of this change can be attributed to an increase in the proportion of adults who report abstaining from any alcohol use, from 10% in 1998 to 15% in 2009.

Q4	What other evidence is there about future demand for help with drug or alcohol problems?
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Local Services

96. This section considers the services that are currently available locally. The national consultation about 'Building recovery In Communities' will lead to a new national service framework to support recovery. The new framework will drive changes to the services that are provided and how they work together over the course of this strategy.
97. Local services are led by specialist teams. The services work in partnership with other agencies – for example Job Centre Plus to support employment, the Supporting People 'Home Works' service for housing related support and East Sussex Fire and Rescue Service to access fire safety assessments in the home.

Drug Misuse – Community Substance Misuse Teams (CSMT)

98. Specialist community drug treatment services were market tested in 2009 (Hastings and Rother) and 2010 (Eastbourne, Wealden and Lewes) to develop Community Substance Misuse Teams (CSMT). The services are provided through a partnership of Sussex Partnership NHS Foundation NHS Trust and CRI (a voluntary sector organisation). There are specialist service bases in Hastings and Eastbourne, and satellite clinics across the county. 'GP shared care' services are provided by trained and experienced doctors as 'enhanced' services, usually within a GP surgery setting. In March 2011, in Hastings and Rother, 34% (N=139/413) of the patients were being seen in these 'shared care' settings, whereas in Eastbourne, Wealden and Lewes 21% (N=88/412) patients were in 'shared care' clinics.

99. About 40% of the pharmacies across East Sussex provide enhanced services for drug misusers. The Needle and Syringe Programme (NSP) provides sterile injecting equipment, safe sharps disposal and advice. Service users who are prescribed a controlled drug that requires supervision are able to receive this medication at some pharmacies. If a service user with a drug problem also misuses alcohol, the Community Substance Misuse Team will address the alcohol problem, too. Sometimes this will include court-ordered alcohol treatment (an Alcohol Treatment Requirement or Specified Activity Requirement).
100. This arrangement serves the areas with the largest numbers of problem drug users well. However, it means limited access to treatment for people who don't live in Hastings or Eastbourne, particularly during the early stages of treatment for people who require substitute opioid medication. To ensure patient safety, guidelines require doctors to prescribe low doses which are increased over a week or so under supervision until the optimal dose is reached. This process is supervised in the specialist clinics, requiring patients to travel to Hastings or Eastbourne. Once stable, patients can receive their medicine from pharmacists, supervised if necessary.
101. One measure used to assess the effectiveness of the treatment system is the proportion of service users engaged in 'effective treatment' – treatment that continues beyond twelve weeks or ends in a planned way before then. The needs assessment tells us that local performance is broadly in line with national performance, and ahead of average performance across the South East region.
102. Compared to the picture for services in England, a greater proportion of people in East Sussex leave treatment successfully within two years. Efforts to reduce the numbers of unplanned discharges across the treatment system appear to have been successful.
103. The critical measure of treatment effectiveness is leaving treatment drug free. In East Sussex, 42% (N=253) of all adults who left treatment in 2009/10 had a successful treatment outcome. This compares favourably to performance across England (38%) and the South East (33%), and has further improved during 2011.
104. Treatment effectiveness varies across different populations in treatment. A higher proportion of females completed treatment in a planned way – 47.9% compared to 42.0% of male clients. A greater proportion of female clients left treatment by being transferred (to treatment in another area) not in custody (8.3%) compared to (2.7%) of males. Overall a higher percentage of males leave treatment as Transferred in Custody (14.2%) compared to (8.9%) of females.
105. Heroin users accounted for 55% (n=306) of the 543 people leaving treatment in 2009/10, and 33% (N=80) of successful completions. 26% (N=80) of heroin users leaving treatment completed treatment successfully. Only 3 of the people completing treatment were crack users. The 'Payment by Results' drug recovery model will be likely to weight successful treatment completion for more complex cases including crack cocaine and heroin users. From April 2012, the number of drug users successfully completing treatment will influence the resources available in future years.
106. Only a small number of people who enter treatment locally are employed. There is no evidence of any improvement in employment as a result of treatment, and some evidence that during treatment employment deteriorates.

107. Only a small number of people who left treatment had experienced changes to their housing situation. A similar number of people reported that their housing situation had either improved, or deteriorated.
108. The relatively small black and minority ethnic (BME) population in East Sussex is reflected in the small number of people from these backgrounds who access treatment. Although the small number means that any interpretation of the data must be cautious, the needs assessment reports that the treatment system appears to be less effective for people from BME groups. Only 25% (N=12) of the BME population who left treatment did so successfully.
109. People using crack cocaine and people referred through the police, courts and prisons are less likely to complete treatment successfully. There is likely to be considerable overlap between these two groups.

Alcohol Misuse – Identification and Brief Advice

110. The importance of ensuring ‘front line’ staff and professional groups can identify alcohol problems and respond effectively is embedded in NICE guidelines (NICE Public Health guideline 24). To support implementation of this guidance Identification and Brief Advice (IBA) training is commissioned from the Health and Wellbeing Team, East Sussex Healthcare NHS Trust. The training programme includes a widely advertised bi-monthly 1 day course and the offer of bespoke training tailored to the needs of specific staff groups and organisational settings.
111. Use of the various e-learning Alcohol Identification and Brief Advice training programmes are also encouraged.
112. Training specifically for primary care staff has been commissioned from the voluntary sector organisation ‘Action for Change’ (which also provides the Community Alcohol Team).
113. From April 2008, an alcohol ‘Directed Enhanced Service’ (DES) has been available to local GP practices. DES are special services or activities provided by GP practices, based on a nationally agreed specification. Directed Enhanced Services must be provided by a Primary Care Trust (PCT) for its population, and practices can choose whether or not to provide these services.
114. The alcohol DES offers GPs a fee to screen each newly registered patient aged 16 years and older for alcohol misuse, and where appropriate deliver brief advice. Participation in the DES Scheme has been lower than anticipated. The table below shows an analysis of uptake during 2009/10 and 2010/11. Participation in the IBA training specifically provided for primary care staff has also been low.

PCT	DES Uptake 2009/10 (Percentage %)	DES Uptake 2010/11 (Percentage %)
NHS East Sussex	56%	61%
NHS Hastings and Rother	58%	61%
NHS East Sussex Downs and Weald	59%	61%

Table 7: GP practices participating in the alcohol DES.

Source: PCT

Alcohol Misuse – Community Alcohol Team (CAT)

115. The Community Alcohol Team in East Sussex is provided by a voluntary sector organisation, 'Action for Change'. The service provides 'tier 2' specialist advice and information, and 'tier 3' non-residential structured treatment interventions.
116. With its main offices in Eastbourne and St Leonards, the Community Alcohol Team provides 'open access' clinics from nineteen different locations across East Sussex, generally for a few hours each week at each location. These clinics provide an opportunity to access the service in person for an initial discussion. Specialist advice is also available by telephone (0300 111 2470) and on the internet www.action-for-change.org
117. Structured treatment is provided through 'alcohol key workers', in primary care settings whenever possible. Every general practice in East Sussex has a named worker. Many practices have provided a consulting room to meet patients. Whilst the service provides a good level of coverage across primary care, it is not available in every GP surgery. Some practices have been unable to provide the space required by the service. Accessing the service can be difficult or delayed in areas where space is not available or is very limited.
118. During 2010/11 the service trialled a thirteen-week project based in the Accident and Emergency department at the Conquest Hospital in Hastings to target frequent users of emergency healthcare with an alcohol-related condition. The hospital identified ten cases. The project was able to contact six of these people, and engaged all of them in treatment. The project also improved liaison and referral from the Accident and Emergency department to the Community Alcohol Team, increasing the number of referrals that were engaged in effective treatment by the service.
119. The Community Alcohol Team includes nurses and a specialist doctor who work with patients who are alcohol dependent to manage withdrawal ('detoxification') in the community. An 'enhanced service' has been developed and GP practices can sign up to work with the Community Alcohol Team to provide the service. However, since the service was approved in 2010 only a small number of GP practices have registered their interest in providing the service.
120. The Community Alcohol Team works closely with the police, courts, probation and local prison to deliver services for offenders.

Safeguarding With Intensive Family Treatment (SWIFT)

121. The partnership has developed a specialist service for families in the child protection process – 'Safeguarding With Intensive Family Treatment' (SWIFT) service. SWIFT is a multi-agency, multi-disciplinary team integrated with Children's Services operations. SWIFT addresses both substance misuse and mental health issues, providing targeted support to families in the child protection process. The service offers a 'duty' assessment and consulting function to other staff working in non-specialist Children's Services roles without requiring a referral and full assessment.

Drug and Alcohol Misuse – Residential Treatment

122. Residential treatment includes inpatient hospital treatment and residential care. Inpatient hospital treatment includes medically managed assessment,

stabilisation and withdrawal from dependent drug or alcohol use and is generally provided for no more than several weeks, often prior to a longer period of residential rehabilitation. Residential rehabilitation is used to provide structured psychosocial interventions and independent living skills in a safe, drug and alcohol free environment. Residential rehabilitation programmes generally last three to six months, sometimes longer.

123. Sussex Partnership NHS Foundation Trust provides inpatient detoxification for both drug and alcohol misusers at Mill View Hospital, in Hove. The hospital provides the treatment in a specialist setting.
124. The care pathway for inpatient treatment for drug misusers is via the community substance misuse team. The team assesses each patient and coordinates care throughout the inpatient episode to ensure continuity of treatment. During 2010/11, 576 occupied bed days were utilised for inpatient drug treatment, with each treatment episode lasting approximately 10 days.
125. The care pathway for inpatient treatment for alcohol misusers is via the community alcohol team. The team assesses each patient and coordinates care throughout the inpatient episode to ensure continuity of treatment. During 2010/11, 462 occupied bed days were utilised for inpatient alcohol treatment, with each treatment episode lasting approximately 7 days.
126. There are no residential rehabilitation facilities in East Sussex. The care pathway for residential rehabilitation is via the relevant community team. Community care assessments are completed by the ESCC Adult Social Care social workers, who are integrated with the Community Substance Misuse Teams and Community Alcohol Team.
127. During 2010/11, 62 residential rehabilitation placements were arranged and 53 were started within the year. Placements were arranged with 13 different providers, reflecting a range of choices expressed by service users. More than half of these placements were arranged with two providers, ANA in Portsmouth (17 placements) and Jigsaw in Bournemouth (16 placements).
128. During 2010/11, 53 residential rehabilitation placements were started. Of these, 47% (N=25) were opiate users, 9% (N=4) were crack users and 45% (N=24) were alcohol users. 70% (N=37) were male and 30% (N=16) were female, which reflects the proportion of male and female service users across the community services. 45% (N=24) of all service users starting residential rehabilitation were referred from criminal justice (probation or prison), 26% (N=14) of all service users starting residential rehabilitation were referred directly from custody.
129. Of the people starting residential rehabilitation, 47% (N=25) had completed an inpatient detoxification beforehand. A further 11% (N=6) had completed a 'medically monitored' detoxification as the first stage of their residential treatment, managed by the residential rehabilitation provider.
130. Only four of the placements made in 2010/11 lasted for more than twelve months. Most were less than 6 months (65%, N=31) and 27% (N=13) were between six and twelve months.

Drug and alcohol interventions for offenders

131. Drug and alcohol interventions are available along the offender pathway.

132. Community drug and alcohol services are part of local Integrated Offender Management (IOM) arrangements. Local IOM teams include staff from the specialist community services (described above) working alongside probation and police. This approach ensures offenders with a history of drug or alcohol misuse are identified and supported effectively. IOM provides an effective care pathway from the prison system into alcohol treatment for offenders with a significant risk of re-offending.
133. The services work in partnership with probation to deliver court-ordered treatment. Orders available to the court include a Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR). DRRs can be ordered as 'high' or 'low' intensity, depending on the severity of the drug problem and offending behaviour. ATRs are intended for offenders who are alcohol dependent. A Specified Activity Requirement (SAR) can also be used to specify alcohol or drug treatment for people whose treatment needs are less intensive.
134. At HMP Lewes, prison drug treatment includes clinical and psychosocial interventions, provided through a partnership between the Healthcare team, prison officers and CRI. These services have been developed separately as the Integrated Drug Treatment System (IDTS); Counselling, Advice, Referral, Assessment and Through-care (CARAT) and prison programmes. The HMP Lewes healthcare service provides medical interventions, alongside psychosocial interventions provided through the CARAT and prison drug treatment programmes. IDTS includes first night prescribing, an inpatient assessment/stabilisation/detoxification service and medical and psychosocial interventions to address drug problems. The Community Alcohol Team provides an 'in-reach' alcohol service as part of prison drug treatment.
135. With the expansion of prison drug treatment more patients are continuing care from the community into prison, between different prison, or from prison into the community. The arrangements for continuity of care between these services rely on effective communication between each team. In East Sussex, the community teams and HMP Lewes team report that the links are effective. There is evidence that the links with teams in other prisons that release men back to East Sussex, and with the women's estate, are less effective.

Q5	Are there other services that should be included in the 'Local Services' section?
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Service User Views – Treatment for Drug Misuse

136. Service users' views are gathered through regular focus groups and survey questionnaire 'postcards', which Sussex Partnership NHS Foundation Trust report every three months. The number of people involved in the groups or providing feedback is a relatively small proportion of the people in treatment. The feedback is generally positive about the services being provided. The feedback is reported to the commissioners and service provider's management team and provides an opportunity for continuous improvement.
137. The 'postcard' feedback presents five statements about patient experience. Each statement describes a positive experience of care – for example 'staff were approachable and friendly'. The patients who have responded generally agree, or strongly agree, with each statement. The chart below reports views expressed through the postcard survey January to March 2011, and includes 141 responses.

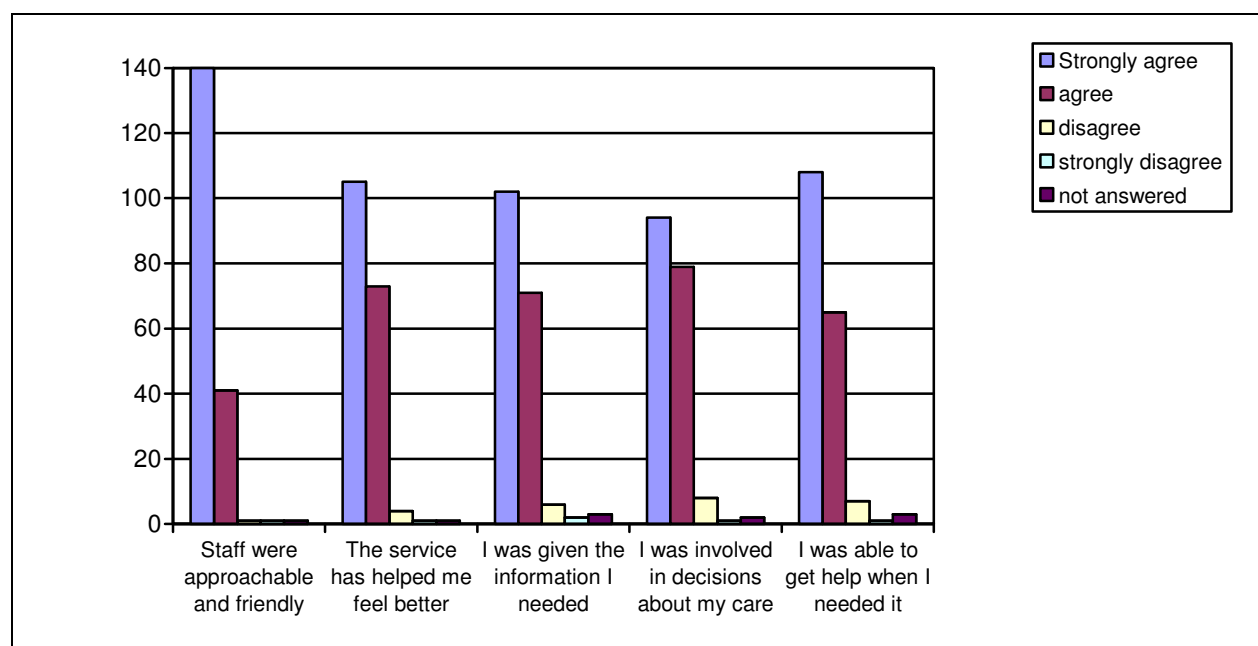


Figure 5: Service User feedback Jan-Mar 2011 Source: Sussex Partnership

138. Feedback from service users involved in focus group during 2010/11 included requests for:

- More structured activities
- More of a focus on recovery and leaving treatment drug free
- More of a separation between using and abstinent people
- Increasing group activities, which could be peer-led
- More ‘aftercare’ activities, and access to informal support after treatment
- More ‘involvement’ like a user-led magazine, website and support
- More help towards training and employment
- Easier access to information about other services

Service User Views – Treatment for Alcohol Misuse

139. Service user views are gathered through regular focus groups with service users and feedback forms. Again, the number of people involved in the groups or providing feedback is relatively small. The feedback is generally positive about the services being provided. The feedback is reported to the commissioners and service provider’s management team and provides an opportunity for continuous improvement.

140. Feedback from service users involved in focus groups during 2010/11 included requests for:

- More structured activities at different times of the week
- Getting training for volunteering and group activities started more quickly
- More opportunities for self-help and peer support
- More support with training and employment
- Better promotion of services in lots of different settings

Contracting arrangements

141. NHS standard contracts have been used to secure the supply of community substance misuse services (Community Substance Misuse Teams and Community Alcohol Team). These are 'non-tariff' services, which means that there is no agreed national payment framework for either the unit of service (the 'commissioning currency'), or the cost (the 'tariff' for NHS services). The current cost was arrived at by market testing the services (an open market competitive tender) during 2009 and 2010.
142. Current contracts include incentives and penalties. As well as incentivising specific targets within the contract, 'Commissioning for Quality and Innovation' (CQUIN) schemes have been developed to incentivise improvements and innovation. Overall, the value of incentives in the contract for the community substance misuse teams is relatively low. Incentives form a greater proportion of the contract for the community alcohol team. Payments for structured treatment interventions are based on activity, and 20% of the contract value is tied to achieving a positive treatment outcome.
143. The agreements for 'enhanced services' provided by local GP practices and community pharmacists are negotiated with the relevant local committees and managed within the arrangements agreed with the local NHS.
144. The prison drug treatment services are provided by three different organisations working jointly under different contracts. From April 2011 the local partnership was given responsibility for commissioning all prison drug treatment. Contracts previously managed by the Ministry of Justice have been assigned to the local NHS and extended to April 2012.
145. A small grants programme has been used to encourage the development of peer-led activities that support mutual aid and peer support.
146. The national drug strategy is introducing 'Payment by Results' drug recovery pilots. The learning from these pilots may lead to the development of a tariff and in any event will need to inform contracting arrangements for both drug and alcohol treatment services. The value of incentives will need to form a greater part of the contract value, and will focus on measurable sustained outcomes.

Current and anticipated resources

147. It is assumed that the overall level of spend on drug and alcohol treatment in East Sussex will remain level throughout the period of the strategy.

COMMUNITY DRUG TREATMENT

SOURCE	2011/12	2012/13	2013/14
Drug Interventions Programme (DIP/HO) via ESCC	£124,944		
Drug Interventions Programme (DIP/DH)	£215,863		
Adult Pooled Treatment Budget 2011/12 (PTB)	£2,385,414		
Young People's Pooled Treatment Budget 2011/12	£200,447		
NHS East Sussex Downs & Weald (PCT)	£753,796		
NHS Hastings & Rother (PCT)	£1,107,304		
Surrey & Sussex Probation Trust	£34,950		
ESCC Adult Social Care	£47,400		
TOTAL	£4,870,118	4,870,118	4,870,118

ALCOHOL TREATMENT

SOURCE	2011/12	2012/13	2013/14
NHS East Sussex Downs & Weald (PCT)	£536,946		
NHS Hastings & Rother (PCT)	£678,296		
ESCC Adult Social Care	£91,100		
TOTAL	1,215,242	1,215,242	1,215,242

ESCC Adult Social Care (residential drug and alcohol treatment)

SOURCE	2011/12	2012/13	2013/14
ESCC Adult Social Care	£235,500	235,500	235,500

PRISON DRUG TREATMENT

SOURCE	2011/12	2012/13	2013/14
Integrated Drug Treatment System (IDTS)	£423,775		
Other drug treatment	£744,462		
TOTAL	£1,168,237	£1,168,237	£1,168,237

Table 8: Current and anticipated resources

03 ► Gap analysis

148. This section draws on the information in earlier sections and identifies gaps in local service provision. Commissioning intentions to address these gaps are proposed in the following section.

Drug Misuse

149. There is no local strategic intelligence about the level of dependence on prescription and OTC medicines.
150. There is limited knowledge about the extent of the use of performance and image-enhancing drugs (PIED – drugs that are generally associated with body-building, like steroids) and effective interventions, despite a significant population of PIED users accessing the needle and syringe programme.
151. The sustained focus on opioids and crack cocaine in previous national drug strategies has meant that services for people using other drugs are under-developed. This is particularly important in relation to the number of people using powder cocaine, which has increased in recent years, and cannabis, which is linked with mental health.
152. Contracts for services focus on activity and process targets (for example waiting times or the proportion of people receiving effective treatment). Incentives for achieving ‘drug free’ outcomes are a relatively small part of the overall contract value. This is out of step with the national strategy, which has a clear focus on payment by results and outcome based commissioning.
153. Unless the number of heroin and crack cocaine users completing treatment is materially increased, the resources available to the partnership are likely to reduce.
154. Commissioners’ efforts to develop recovery communities have not created sustainable models of peer support and mutual aid, over and above those that were already operating locally.

155. Although there has been a significant expansion of supervised consumption arrangements with pharmacies across East Sussex, 'shared care' arrangements with GP practices are still fairly limited and treatment services are under-developed outside Hastings and Eastbourne.
156. The requirement for patients to attend titration clinics in Hastings and Eastbourne is a significant barrier to starting treatment for people who live outside those towns.
157. Services that provide psychosocial interventions for drug misusers do not appear to be recording the activity properly and activity is significantly under-reported.
158. Whilst drug-related offending has significantly reduced, there are still a significant number of people who commit offences that are linked to their use of drugs like heroin and cocaine.
159. Although the resource allocated to 'tier four' residential rehabilitation has been increased each year there is still unmet demand. As the focus of national strategy turns to 'recovery' it may stimulate further demand. Using 'slippage' to fund this aspect of treatment reduces commissioners' and providers' ability to plan spending.
160. The needs assessment describes the limited knowledge about how people learn about services. 60% of referrals are recorded as 'self', 10% 'GP' and 14% the police, courts or prison.
161. Dried Blood Spot Testing (DBST) is available in community services, but is not yet being used in the family service or at HMP Lewes.
162. The partnership has not yet analysed the information it collects about the people who use the needle and syringe programme. A detailed analysis would help the partnership to understand more about the population that are using the service, and unmet need.
163. Service users who receive the service as part of a 'drug rehabilitation requirement' generally value the additional structure and support provided by the programme. They have also been vocal about the need to develop programmes that offer more structure and support for people whose treatment programme is voluntary, rather than court-ordered. Some service users experience the transition from required regular attendance and group activities to less regular attendance and individual meetings with a key worker as a withdrawal of support.
164. Although 'Home Works', the generic floating housing support service funded by Supporting People, is accessible across East Sussex, access to the specialist 'Prevention of Offender Accommodation Loss' (POAL) project and rent deposits is unequal, and relies on short-term funding.

Alcohol Misuse

165. The PCT/ESCC Joint Strategic needs Assessment was published in 2009 and provides a solid basis for current commissioning priorities. However, as more people enter treatment it will be important to gain a better understanding of met need, and identify any populations that are under-represented in treatment.

166. There isn't yet a comprehensive audit of local practice using NICE clinical guidelines for alcohol use disorders (CG115). An audit may identify significant opportunities for improvement.
167. The development of alcohol services hasn't focused specifically on the needs of older people, which are likely to be different to the needs of younger adults.
168. The Department of Health (2009) 'high impact' changes have not yet been fully implemented. In particular, not all GP practices are routinely applying IBA to patients and links with the acute hospitals could be improved.
169. Extending the reach of IBA in primary care to 'at risk' groups such as those with chronic conditions, e.g. hypertensive diseases, digestive diseases and cardiac arrhythmias and other known risk factors would identify risky drinkers who would benefit from brief advice, or referral for structured treatment. This could be provided by adapting the 'Directed Enhanced Service' for newly registered patients to develop a 'Local Enhanced Service' that extends IBA to all patients in 'at risk' groups.
170. The Community Alcohol Team has developed referral pathways with acute hospitals, but referral rates have remained low. The Department of Health (2009) recommends specialist alcohol nurses should be linked to accident and emergency units.
171. Local enhanced services to develop medical detoxification services in primary care have been agreed, but few practices have taken up the opportunity to develop this service and access to community alcohol detoxification remains relatively poor.
172. 'Aftercare' is limited. Some patients who have expressed longer term support needs have experienced the development of services in primary care as a reduction in the support available. Focusing on developing evidence-based individual care has reduced opportunities for service users to develop 'recovery communities' with other people accessing 'drop-in' informal groups in specialist services.
173. The focus of IBA training has been to offer a programme of training to practitioners from a range of key professional groups and settings. An understanding of the impact of this training on the behaviours on practitioners back in the work place in relation to screening (using a validated tool), provision of brief advice and referral is limited. A future programme of work to develop the capabilities of practitioners to identify those at risk and provide brief advice and/or referral should continue to focus on key staff groups and setting following NICE PH24 recommendations. Integral to this work will be the engagement of workplace service leads, including those responsible for learning and development to encourage the incorporation of IBA into routine practice. The collection of data about the number of individuals screened, receiving brief advice and referred to treatment services as a result of training will provide useful data on the benefits and outcomes of training as well as indicating patterns of drinking behaviours among different population groups.
174. There remain some areas in East Sussex where access to the Community Alcohol Team is limited because of a lack of accommodation for the service. The service works with a wide range of partners to engage with people in rural areas in East Sussex, where accommodation is a particular challenge.

175. The needs assessment proposed a service model that included ‘fixed bases in the high need coastal areas’. The Community Alcohol Team provides specialist bases open throughout the week in Eastbourne and St. Leonards. In other areas, services are available for part of the week in shared-use buildings.
176. Several of the issues with a ‘treatment’ focus that were identified as gaps in the needs assessment have not yet been addressed. These are:
- Clarifying the pathways for alcohol-related dementias;
 - Developing clear guidance about addressing the needs of people in treatment whose condition doesn’t improve;
 - Exploring whether further work is required on foetal alcohol spectrum disorder.

Substance Misuse and Offenders

177. Local services report good links with the IDTS at HMP Lewes and effective ‘continuity of care’ arrangements, but the data suggests that half of the people leaving treatment in prison do not re-engage with treatment in the community. Local drug treatment services report that communication with prisons outside East Sussex is sometimes poor, particularly for female offenders leaving prison and returning to East Sussex.
178. Prison drug treatment at HMP Lewes has been developed over a number of years, with different parts of the service contracted to different providers. The transfer of responsibility for prison drug treatment from the Ministry of Justice to the Department of Health to achieve funding with ‘one pot, one purpose’ provides the partnership with the opportunity to redesign and market test these services under a single specification.

Q6	Are there other gaps that can be identified from the information and analysis, or other evidence?
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04 ► Commissioning intentions

179. The following section describes the DAAT’s commissioning intentions. Commissioning intentions describe the actions that strategic partners will take to address the gaps. Each action is followed by an outcome statement, which describes a bit more about what the action means and how it will improve services.
180. The actions include recommendations from the drug treatment needs assessment, harm reduction strategy and the local Confidential Inquiry Into Drug Related Deaths (2010).
181. The strategy recommends actions within these four domains:
- Commissioning for outcomes and moving towards a focus on results
 - Maintaining and improving access to treatment
 - Delivering recovery and progress within treatment
 - Achieving outcomes and successful completions
182. Each domain starts with a summary of the DAAT’s priorities. The commissioning intentions for that domain are then organised to describe those that affect the

whole care group (i.e. people who misuse drugs or alcohol), then drug misusers, and then alcohol misusers.

Commissioning for outcomes and moving towards a focus on results

Summary of priorities:

- Improving the quality of information about prison drug treatment and alcohol treatment
- Integrating the learning from local and national pilots and from user involvement activities in commissioning

Commissioning intentions for the whole care group

183. Continue flagging those clients with missing 'blood borne virus' data at the Treatment Performance Group.

Outcome: There are fewer new infections, and more people with infections get treatment.

184. Work to be done around improving the quality of the 'Treatment Outcomes Profile' data, specifically in relation to Section 3: Crime

Outcome: Better quality information about what happens as a result of treatment, particularly around offending behaviour, is used to improve services.

185. Continue discussions with Nebula around developing a 'Quick Report' that could be made available to users in which they could specify a date range, even a future one, and obtain a sensible list of review dates in a suitable format that staff could use as a control document in planning Care Plan Reviews

Outcome: Better quality information about what happens as a result of treatment is used to improve services.

186. Key workers to identify at earliest possible point those clients leaving treatment successfully in order to complete exit TOP within guidance and maintain level of performance.

Outcome: Better quality information about what happens as a result of treatment is used to improve services.

187. Feedback from the substance misuse service users will be sought on a regular basis to feed into contract and performance management processes.

Outcome: Patients are engaged in planning and improving the services they use.

Commissioning intentions for drug misusers

188. Learning from the 'Performance and Image Enhancing Drug' pilot will be used to inform future service design.

Outcome: Services for people using steroids are shaped by testing out innovative service design that involves service users in planning and improving services.

189. When the Harm Reduction Strategy is refreshed, analysis should be carried out around gaps in pharmacy service provision as well as mapping of pharmacies in relation to in treatment population.

Outcome: Plans for the needle and syringe programme ensure services are accessible by comparing where people live with information about where services are.

190. Commissioners will develop strategic intelligence about the level of dependence on prescription and OTC medicines.

Outcome: Better quality information about need is used to improve services.

191. Review the IDTS section in future needs assessments in order to monitor and address data quality concerns.

Outcome: Better quality information about need is used to improve services.

192. The partnership will apply the learning as it emerges from the Drug Recovery Payment By Results (PbR) pilot areas.

Outcome: Services use outcome-focused contracts that improve outcomes.

193. All contracts will include financial incentives for achieving recovery outcomes.

Outcome: Services use outcome-focused contracts that improve outcomes.

194. Ensure impact of DIP Intensive is reviewed after it has been operational for 12 months. The review should include a focus on the needs of 18-25 year olds committing trigger offences The review shall also consider the case for the introduction of DIP Intensive status on a self-funded basis in Eastbourne, Lewes and Wealden.

Outcome: Drug related offending is reduced.

Commissioning intentions for alcohol misusers

195. The DAAT's annual needs assessment will include a focus on primary alcohol misusers to develop knowledge about local need and identify populations that are under-represented in treatment.

Outcome: Better quality information about need is used to improve services.

196. The partnership shall assess the need for further work on foetal alcohol spectrum disorder.

Outcome: Better quality information about need is used to improve services.

197. Local practice will be audited using the NICE alcohol use disorders clinical guidelines. The audit will be used to develop a plan that identifies any deficits in local care pathways, the resources required and an appropriate timetable for implementation. The plan will reflect local healthcare needs and services. NICE note that full implementation of local plans "may take a considerable time".

Outcome: Better quality information about need is used to improve services.

Q7	Drawing on the earlier gap analysis, are these the right priorities for commissioners?
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Maintaining and improving access to treatment

Summary of priorities:

- Drug testing on arrest to identify offenders who use 'class A' drugs in Hastings and Rother from April 2011. Commissioners need to consider the case for extending this into the Eastbourne, Wealden and Lewes.
- Marketing services for a wider range of substance misusers, targeting different groups in different ways
- Ensuring services in rural areas and for people in rural communities are more visible
- Implementing any outstanding 'high impact' changes for alcohol misuse
- Expanding access to community alcohol detoxification

Commissioning intentions for drug misusers

198. Services will be developed for people using stimulants (powder cocaine and amphetamine type stimulants) and cannabis, and promoted towards the people who use these drugs.

Outcome: Services reach people who could benefit from treatment, but don't perceive services to be for them and are not currently asking for help.

199. Hastings and Rother will be designated a 'DIP Intensive' area. This will materially increase the number of people arrested for a trigger offence who are required to be assessed, and subsequently engage in treatment.

Outcome: Drug related offending is reduced.

200. Services will be developed in areas outside Hastings and Eastbourne that enable titration on opioid medication without daily travel to the specialist services in those towns.

Outcome: More people start treatment in areas outside Eastbourne and Hastings.

201. Ensure that services are providing a visible service that is readily accessible in rural areas

Outcome: More people start treatment in areas outside Eastbourne and Hastings.

202. The partnership will improve access to treatment by developing marketing plans that segment the population and that address service users of different ages, genders, using different drugs and so on, and setting stretching ambitions to reach more of each of these populations.

Outcome: Better quality information about need is used to improve services.

203. Increase awareness of the available services offered by pharmacies to encourage more people to access them.

Outcome: More sterile injecting equipment is distributed to people who will use it.

204. DIP Intensive Implementation Group to monitor 'peak times' of testing on arrest so an appropriate response can be developed if trends are identified.

Outcome: Better quality information about need is used to improve services.

Commissioning intentions for alcohol misusers

205. Commissioners will consider incentivising IBA in primary care for registered patients in 'at risk' groups to identify risky drinkers who would benefit from brief advice, or referral for structured treatment.

Outcome: Better quality information about need is used to target services towards the people who are most likely to benefit from them.

206. Specialist alcohol staff will be linked to accident and emergency units.

Outcome: Reduced demand for emergency care by people who misuse alcohol.

207. Alternative models to develop services that manage alcohol withdrawal (detoxification) in the community will be explored with clinical commissioning groups.

Outcome: Redesigned services improve treatment options for patients.

208. A social marketing approach will be adopted to identify the people who could benefit from treatment, and promote services in ways that encourage them to access treatment.

Outcome: Better quality information about need is used to improve services.

209. A social marketing approach will be adopted to ensure the specialist services for alcohol misusers are marketed in a way that suits the needs of older people.

Outcome: More older people get effective help for alcohol problems.

Q8	Drawing on the earlier gap analysis, are these the right priorities for commissioners?
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Delivering recovery and progress within treatment

Summary of priorities:

- Developing peer support and mutual aid
- Expanding access to structured group activities
- Delivering more services outside Eastbourne and Hastings
- Providing more services through pharmacies
- Increasing the resource allocated to residential treatment on a recurrent basis
- Market-test prison drug treatment at HMP Lewes

Commissioning intentions for the whole care group

210. Substance misuse provider organisations will support the development of local SMART Recovery (UK) groups as SMART Recovery partners. The specialist

drug and alcohol services will include SMART Recovery interventions. Local 'recovery champions' within each service will be responsible for establishing local peer support and mutual aid groups that have adopted the SMART Recovery approach.

Outcome: A wider range of peer-led group activities is available to support recovery from drug and alcohol misuse.

211. Services that focus on recovery will be developed in areas outside Hastings and Eastbourne.

Outcome: More people access treatment and 'aftercare' activities in areas outside Eastbourne and Hastings.

212. More support will be given to vulnerable families including parenting support and health promotion guidance.

Outcome: The needs of parents who seek help for drug or alcohol misuse will be properly assessed and responded to.

Commissioning intentions for drug misusers

213. The resource allocated to 'tier four' residential rehabilitation will be increased on a recurrent basis to reduce the reliance on 'slippage' and improve planning.

Outcome: More people benefit from abstinence-focused residential treatment.

214. Extend pharmacy-based treatment delivery to include more complex patients whose treatment includes management of alcohol misuse by offering a 'level 2' enhanced service that includes breath alcohol measurement.

Outcome: More people receive treatment in community pharmacies, closer to home.

215. Improve the recording of 'Structured Psychosocial Interventions', the 'counselling' that is provided as part of drug treatment.

Outcome: Better quality information about the people who use services is used to improve them.

216. Improve sharing of information within the services and establish a clear process highlighting the responsibility for entering Tier 4 data into Nebula.

Outcome: Better quality information about the people who use services is used to improve them.

217. The impact of the 'risk planning' training will be reviewed, with a particular focus on domestic abuse.

Outcome: Services identify and reduce the risk of domestic abuse.

218. Harm Reduction Group membership should be expanded to include a service in relation to domestic abuse.

Outcome: Services identify and reduce the risk of domestic abuse.

219. Continue to roll out the Dried Blood Spot Testing initiative in the county.

Outcome: More people with infections get treatment.

220. Look at the potential for additional pharmacies to provide extended cover.

Outcome: More sterile injecting equipment is distributed to people who will use it.

221. Work to be done around establishing new pathways and mechanisms in which HMP Lewes can alert CJIT teams to the release of clients who had been receiving treatment in prison.

Outcome: More people who leave prison with a drug treatment need enter community drug treatment.

222. Investigate the follow up action that is taken when a person who is currently receiving treatment for drug misuse is arrested – with a view to ensuring that repeated arrests of persons receiving treatment triggers a care plan review.

Outcome: Drug related offending is reduced.

223. Responsibility for commissioning all prison drug treatment passed directly to the DAAT from 1 April 2011, and there will be an opportunity to develop and market-test the prison drug treatment at HMP Lewes.

Outcome: Prison drug treatment is redesigned to improve outcomes.

Q9	Drawing on the earlier gap analysis, are these the right priorities for commissioners?
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Achieving outcomes and successful completions

Summary of priorities:

- Developing 'aftercare' activities and recovery communities
- Sustaining the focus on improving treatment outcomes, particularly for groups that are identified as less likely to leave treatment successfully
- Ensuring clinical audit is routinely part of service improvement activities
- Providing additional help with housing for more complex cases
- Providing more help with training and employment
- Improving continuity of care for female offenders

Commissioning intentions for the whole care group

224. Commissioners will adopt the learning from the RSA Whole Person Recovery project in West Sussex, and implement a similar programme of activity to implement the model in East Sussex. This strategic approach to developing recovery communities will coordinate activity and stimulate the development of peer support groups. Members of these groups will be encouraged to take an active role in planning services.

Outcome: A wider range of peer-led group activities is available to support recovery from drug and alcohol misuse.

225. Treatment providers shall complete a programme of clinical audit to improve practice and encourage a culture of continuous improvement. Audits to be reported to the Treatment Performance Group.

Outcome: Services are continuously improved.

Commissioning intentions for drug misusers

226. Follow up work, including focus groups, should be carried out with individual service users from BME populations about their experiences of the service to identify opportunities for improvement.

Outcome: Better quality information about the people who use services is used to improve them.

227. Further expansion of GP shared care.

Outcome: More people receive treatment in primary care settings, closer to home.

228. Continue to focus on improving planned discharges and reducing unplanned discharges.

Outcome: More people leave treatment in a planned way, drug free.

229. Further analysis needs to be carried out to understand the reason why specific groups have a lower planned exit rate.

Outcome: Better quality information about the people who use services is used to improve them.

230. As half the population leaving treatment is aged 30 to 44, focus should be on ways of reducing these clients leaving treatment in an unplanned way. What factors affect this group staying in treatment?

Outcome: Better quality information about the people who use services is used to improve them.

231. Develop ways to keep male clients within the 30 to 44 age group out of custody in order to increase the percentage completing treatment. Possible links to Courts, Probation service and CJIT for those clients established in drug treatment.

Outcome: More people leave treatment in a planned way, drug free.

232. Explore reasons why clients in treatment between 2 and 4 years are more likely to be transferred in custody.

Outcome: Better quality information about the people who use services is used to improve them.

233. Further analysis and consultation needed to explore if there is an optimal length of time to keep people in treatment in order to stabilise them, reduce offending and complete treatment.

Outcome: Better quality information about the people who use services is used to improve them.

234. Continue to focus on and improve those modalities and discharges ending in a planned way, and reduce the numbers of those finishing with an unsuccessful outcome.

Outcome: More people leave treatment in a planned way, drug free.

Housing and Employment:

235. The DAAT will fund a 'rent deposit' scheme and part-fund the Preventing Offender Accommodation Loss (POAL) project for two years to establish the service across East Sussex and ensure its effectiveness is properly evaluated.

Outcome: Offenders with accommodation needs will receive additional support to maintain appropriate housing.

236. Ensure effective pathways are in place for those individuals with a housing and/or employment need, specifically targeting those in the most vulnerable groups – those aged 18 to 44.

Outcome: Service users with accommodation and employment needs will receive the help they need to achieve and maintain recovery.

237. Consult with services and service users to establish if the treatment structure in East Sussex is inhibitive to people continuing to work whilst in treatment

Outcome: Services will engage service users in planning and improving services.

238. Improve the integration of Job Centre Plus with substance misuse services.

Outcome: Effective links between substance misuse treatment and Job Centre Plus will support more people into work.

239. Audit of services using NTA/Job Centre Plus joint working protocol.

Outcome: Effective links between substance misuse treatment and Job Centre Plus will support more people into work.

240. Carry out an audit of cases for those clients with a housing need over the past 6 months

Outcome: Better quality information about the people who use services is used to improve them.

241. Further analysis needed to establish what services or assistance is available to help clients maintain the accommodation they are in, whilst in treatment.

Outcome: Better quality information about the people who use services is used to improve them.

Q10 Drawing on the earlier gap analysis, are these the right priorities for commissioners?
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Workforce development

Commissioning intentions for drug misusers

242. Health improvement action will focus on developing a strategic response to the primary prevention learning and development needs of practitioners and the wider public health workforce. This forms part of a wider learning and development programme across a number of lifestyle risk factors and behaviours.

Outcome: Coordinated health improvement will target staff in key roles. More people with drug problems will be identified, and enter effective treatment.

243. The “Performance and Image Enhancing Drug” (PIED) pilot will be used to develop the knowledge and skills of the staff directly involved, and transfer these capabilities to other staff in the substance misuse services.

Outcome: Services for people using steroids and associated substances are shaped by testing out innovative service design that involves service users in planning and improving services.

Commissioning intentions for alcohol misusers

244. Identification and Brief Advice (IBA) will be strategically targeted towards practitioners and organisational settings identified in the NICE Public Health (PH24) Guidance. Work will be undertaken with relevant service leads/strategic managers, including those responsible for learning and development, to encourage IBA being undertaken as part of routine practice and the integration of training into learning and development programmes for relevant practitioners. Work will also be undertaken to align this work to Workplace Alcohol Policies and Workforce Development Strategies, where appropriate.

Outcome: Coordinated health improvement will target staff in key roles. More people with alcohol problems will be identified, and enter effective treatment.

245. Work will be undertaken to encourage the use of e-learning IBA opportunities as an alternative or as part of a blended learning solution for some organisations.

Outcome: Coordinated health improvement will target staff in key roles. More people with alcohol problems will be identified, and enter effective treatment.

Harm Reduction

Commissioning intentions to reduce drug related deaths

246. All Serious Untoward Incident (SUI) reviews will be shared with the authors of Confidential Inquiries at the time of completion.

Outcome: Confidential Inquiries will embed the learning from providers’ internal reviews.

247. Naloxone will be distributed as widely as possible. Service users and carers will continue to be offered training about how to manage an overdose.

Outcome: Fatal opioid overdoses will be prevented.

248. All of the recommendations in the Confidential Inquiries into Drug Related Deaths will be routinely shared with mental health services.

Outcome: Risks for people with both mental health and drug misuse problems will be reduced.

Commissioning intentions from the DAAT Harm Reduction Strategy (Year 1)

249. Work closely with the Health Protection Unit to improve screening and referral pathways for tuberculosis.

Outcome: More people with TB are identified and treated.

250. Consider the development of 'level two' Needle and Syringe Programme services.

Outcome: More sterile injecting equipment is distributed to people who will use it.

251. NSP provision will be developed further to ensure the service is available in the evenings and on Sundays.

Outcome: More sterile injecting equipment is distributed to people who will use it.

252. Sharps disposal – The use of community disposal facilities will be considered with the involvement of the Health Protection Unit in any 'problem' areas identified.

Outcome: Needle litter remains low despite increased distribution of equipment.

253. Tetanus immunisation will be offered to people using the Needle and Syringe Programme and injecting drug users entering drug treatment as appropriate.

Outcome: Patients complete tetanus vaccination programmes.

254. Findings from the NTA's naloxone pilots will be used to inform local activities that increase carers' involvement in overdose management training (including naloxone distribution).

Outcome: Fatal opioid overdoses will be prevented.

255. Providers' clinical audit plans should include a harm reduction focus, including: offering smoking cessation interventions; HBV vaccination booster doses for service users in treatment for more than five years with a continuing risk.

Outcome: Services are continuously improved.

256. There will be an evaluation of the harm reduction interventions delivered by the residential rehabilitation services that are used by the partnership, with recommendations for improvement as appropriate.

Outcome: Services are continuously improved.

Commissioning intentions from the DAAT Harm Reduction Strategy (Year 2)

257. Consider plans to introduce routine testing for blood borne viruses at GP registration and/or hospital admission.

Outcome: More people with infections get treatment.

258. Sexual partners and household contacts of service users accessing treatment should be supported and screened for blood borne viruses, and vaccinated against HAV and HBV using the combined 'Twinrix' vaccination as appropriate.

Outcome: There are fewer new infections, and more people with infections get treatment.

259. Provide provision for those being discharged from A&E to have access to clean injecting equipment.

Outcome: More sterile injecting equipment is distributed to people who will use it.

260. Develop outreach for the 'Special Groups' identified by the NICE NSP guidelines.

Outcome: More sterile injecting equipment is distributed to people who will use it.

261. An investigation to take place into the continuity of care for female prisoners so that practices can be improved. A further investigation to then take place 12 months after the initial investigation to check progress

Outcome: More female offenders experience continuous care from prison to community drug treatment.

04 ► Next steps

How the strategy will be implemented

262. East Sussex DAAT will continue to be the strategic partnership that oversees the implementation of the strategy. With a focus on treatment for adult drug and alcohol misusers, the DAAT's Joint Commissioning Group will lead this area of work.
263. An annual 'treatment plan' will be developed each year to describe how the next priorities in the strategy will be implemented. Running from April to the following March, these plans will be agreed by the DAAT's Joint Commissioning Group, which will also be responsible for ensuring the plans are delivered. The annual plans will include both alcohol and drug misuse priorities. The plans will describe specific outcomes, a timetable for delivery, who will lead progress towards the outcomes and any 'milestones' that demonstrate progress along the way. The objectives within the treatment plans will be included in contracts with providers and DAAT partners' delivery plans, as appropriate.

Monitoring arrangements

264. The DAAT Joint Commissioning Group will consider progress with the treatment plan every three months. The group will identify any 'exceptions' where objectives or milestones are not being achieved. The group will be responsible for agreeing any remedial action to ensure the plan is achieved. Annual treatment plans and performance reports will be published on the DAAT's website (www.safeineastsussex.org.uk).

268. Indicators that address drug and alcohol misuse are explicitly included in the framework. The framework describes the NICE quality standards for 'alcohol dependence' as a particularly relevant topic area for domains 1 and 2, and for 'drug use disorders' as a relevant topic area for domain 2. As the approach is developed during the life of this strategy, the DAAT will ensure that local plans reflect the strategic priorities.

Appendix 01 ► Figures and Tables

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Appendix 02 ► Impact of previous strategies

269. The following tables report an evaluation of the previous strategies (approved in June 2008) by comparing selected performance metrics through time. The selected baseline is performance at 31 March 2008. The data for 2010/11 is a 9 month sample (1 April – 31 December), so a full year effect (FYE) has been estimated by multiplying the number of starts by 1.33. Figures indicated by “*” means fewer than 5 forms, and so not reported by NDTMS.

Hastings and Rother Community Substance Misuse Team						
Metric	Q4 07/8	Q4 08/9	Q4 09/10	Q3 10/11	Source	Comment
Number of individuals starting a new treatment episode YTD	143	181	198	168 (224 FYE)	NDTMS	+56.6% improved
Number of individuals currently receiving specialist prescribing	257	297	343	286	local	At the level anticipated by the tender
Number of individuals currently receiving GP prescribing	83	87	97	128	local	Improved but fewer than the 192 places anticipated
Total prescribing / % 'shared care'	340 / 24.4%	384 / 22.7%	440 / 22%	414 / 31%	local	Improved but not yet achieving 480 activity Tender envisaged 40% of treatment in 'shared care'
% new presentations YTD offered HBV vaccination	79%	96%	100%	99%	NDTMS	+20% improved
% individuals in treatment previously or currently injecting with an HCV test	65.3%	85.4%	88%	86%	NDTMS	+20.7% improved
% of patients starting first episode of treatment within	68%	100%	100%	98%	NDTMS	+30% improved

3 weeks						
Average wait for first intervention – specialist prescribing (weeks)	Not available	0.35	0.56	0.43	NDTMS	No more than 4 days.
Discharges – planned YTD	60 (21.9%)	46 (25.3%)	67 (39%)	80 (54%)	NDTMS	Improved above 50% target.
Discharges – unplanned YTD	214 (78.1%)	116 (63.7%)	86 (41%)	29 (20%)	NDTMS	Improved and enabling planned to exceed 50% (there are 25%-30% transferred to other services or custody, too).
TOP start	Not available	83.3%	100%	96.9%	NDTMS	Good
TOP review	Not available	36.4%	96.8%	95.2%	NDTMS	Good
TOP exit	Not available	*	93.8%	100%	NDTMS	Good

Table 9: Impact evaluation – Hastings and Rother CSMT

Eastbourne, Wealden and Lewes Community Substance Misuse Team						
Metric	Q4 07/8	Q4 08/9	Q4 09/10	Q3 10/11	Source	Comment
Number of individuals starting a new treatment episode YTD	140	212	193	172 (229 FYE)	NDTMS	+63.6% improved
Number of individuals currently receiving specialist prescribing	308	333	365	362	local	At the level anticipated by the tender
Number of individuals currently receiving GP prescribing	48	66	68	81	local	Improved but fewer than the 120 places anticipated
Total prescribing / % 'shared care'	365 / 13%	399 / 20%	433 / 16%	443 / 18%	local	Improved but not yet achieving 480 activity Tender envisaged 25% of treatment in 'shared care'
% new	87%	89%	100%	98%	NDTMS	+11% improved

presentations YTD offered HBV vaccination						
% individuals in treatment previously or currently injecting with an HCV test	54%	71%	81%	85%	NDTMS	+31% improved
% of patients starting first episode of treatment within 3 weeks	97%	100%	100%	98%	NDTMS	Sustained
Average wait for first intervention – specialist prescribing (weeks)	Not available	0	0.17	0.27	NDTMS	Less than 2 days.
Discharges – planned YTD	30 (18%)	28 (21%)	39 (27%)	88 (56%)	NDTMS	Improved above 50% target.
Discharges – unplanned YTD	137 (82%)	96 (73%)	60 (42%)	23 (15%)	NDTMS	Improved and enabling planned to exceed 50% (there are 25%-30% transferred to other services or custody, too).
TOP start	Not available	97%	97.1%	96.9%	NDTMS	Good
TOP review	Not available	14.3%	88%	95.2%	NDTMS	Good
TOP exit	Not available	*	91.7%	100%	NDTMS	Good

Table 10: Impact evaluation – Eastbourne, Wealden and Lewes CSMT

Appendix 03 ► Glossary of Abbreviations

270. Abbreviations are explained in the text the first time they appear. Commonly used abbreviations are also included in the table below.

DAAT	Drug and Alcohol Action Team
DES	Directed Enhanced Service
NHS ESDW	NHS East Sussex Downs and Weald
NHS HR	NHS Hastings and Rother
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
IBA	Identification and Brief Advice
IDU	Injecting Drug User
IOM	Integrated Offender Manager
NICE	National Institute for Health and Clinical Excellence
NSP	Needle and Syringe Programme
NTA	National Treatment Agency
NWPHO	North West Public Health Observatory
OCU	Opiate or Crack User
OTC	'Over the counter' medicines – e.g preparations containing codeine
PCT	Primary Care Trust
PDU	Problem Drug User (a person who uses opiates or crack cocaine, also referred to as an OCU)
PHO	Public Health Observatory
PIED	'Performance and Image Enhancing Drugs' – generally drugs that are associated with body-building, for example steroids.
TOP	Treatment Outcomes Profile

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