DERBYSHIRE COUNTY COUNCIL

HEALTHIER COMMUNITIES IMPROVEMENT AND SCRUTINY COMMITTEE

COMMISSIONING ALCOHOL TREATMENT SERVICES IN DERBYSHIRE

A HEALTH OVERVIEW AND SCRUTINY REVIEW

REVIEW REPORT

DECEMBER 2006

DERBYSHIRE County Council
Improving life for local people

DERBYSHIRE COUNTY COUNCIL

HEALTHIER COMMUNITIES
IMPROVEMENT AND SCRUTINY COMMITTEE

COMMISSIONING ALCOHOL TREATMENT SERVICES IN DERBYSHIRE

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FOREWORD

Alcohol misuse contributes to a wide range of diseases, disorders and injuries, and has an adverse impact on social life.

Alcohol is a cause of several cancers, including cancer of the mouth, oesophagus and larynx. We have also heard of the damage it can do to the body, in particular liver cirrhosis.

Many of us will know people who, at times, have struggled to control their drinking. They may be family members or work colleagues or friends, but we will have witnessed the adverse social effects of problem drinking – perhaps a breakdown in a relationship or marriage, the loss of a job, children and young people taking on extra responsibilities or not wanting to bring friends home.

So it was a concern to the Health Scrutiny Committee when we heard that there was potential for the loss of some of the alcohol treatment services in Derbyshire from April 2007, due a lack of funding. It was a greater surprise when we heard that the type of work which currently remains unfunded from next year relates to early interventions with people – trying to prevent admissions to Hospital or Mental Health Services.

We have listened to Derbyshire County Primary Care Trust, the main commissioners of Derbyshire's alcohol treatment services, and to Derbyshire County Council, who provide over £140,000 funding fro treatment services every year. We have also listened to providers of alcohol treatment services, including the North Derbyshire Alcohol Advisory Service, Derbyshire Mental Health Services NHS Trust, Derby Hospitals NHS Foundation Trust and Chesterfield Royal Hospital NHS Foundation Trust.

Most importantly, we have listened to some users of Derbyshire's alcohol treatment services, in particular representatives from the Swadlincote Alcohol Self Help Group and Derbyshire Voice, and alcohol services clients across Derbyshire.

We would like to thank all of those who have participated, and particularly those who came to our round table event in October 2006. Over 35 people attended, and all stayed for the whole session.

We know that Derbyshire County Primary Care Trust and Derbyshire County Council listen to our report. We have tried to research as much evidence as we can to support the recommendations.

We hope that we will have some impact on improving services for people in the future.

County Councillor Roger Wilkinson
Vice Chair - Improvement and Scrutiny Committee – Healthier Communities

1.	**Background to the Review**
1.1	**It is estimated that evidence-based alcohol treatment in the UK suggests that for every £1 spent on alcohol treatment, the public sector saves £5.** It is also estimated that alcohol misuse is costing £20 billion a year in England, including alcohol-related disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace, and problems for those who misuse alcohol and their families, including domestic violence. Total healthcare costs related to alcohol misuse have a middle estimate of £1.6 billion, the annual cost of other primary care services reaches a total of almost £0.5 billion and around £0.5 billion (35%) of accident and emergency (A&E) attendance and ambulance costs may be alcohol related.
1.2	In Derbyshire, the total spend on alcohol treatment services is difficult to quantify because of the nature of commissioning arrangement. However, it is understood that funding of Tier 2 and Tier 3 services is around £0.5 million per annum – a fraction of the potential saving.
1.3	**From April 2007, no funding has been identified to continue the delivery of Tier 2 alcohol treatment services – early interventions – in South Derbyshire.** This means that many people with hazardous or harmful drinking habits will miss out on support services. Some may become dependent drinkers, causing physical damage to their body, and becoming heavy consumers of health services in the future. (More information on the Tiers of alcohol treatment services is set out in Appendix 1).
1.4	**The purpose of the Health Scrutiny project is:** • ***To identify the current and future accountabilities and responsibilities for the commissioning and delivery of Tier 2 and Tier 3 alcohol treatment services across Derbyshire[1].*** • ***To make recommendations in relation to the future commissioning and delivery of Tier 2 and Tier 3 alcohol treatment services in Derbyshire.***

[1] Alcohol treatment services in the Glossopdale area of North Derbyshire are not included in the scope of this review. These services are commissioned by Tameside and Glossop Primary Care Trust, and there are plans to continue the commissioning and delivery of Tier 2 and Tier 3 services beyond April 2007.

1.5	**In undertaking the review, County Councillors wanted to:** • **Seek a better understanding of roles and responsibilities of NHS organisations and local authorities in commissioning and providing alcohol treatment services in Derbyshire.** • **Seek a better understanding of the funding streams for alcohol treatment services across Derbyshire, and in particular any differences in provision of services across the County.** • **Seek a better understanding of needs of users and potential users of alcohol treatment services, in particular Tier 2 and Tier 3 services.** • **Influence the delivery of alcohol treatment services, through 2007/2008, and onwards.**
1.6	The World Health Organisation identifies alcohol use disorders in three categories:
1.6.1	**Hazardous drinking** – people drinking above recognised "sensible" levels but not yet experiencing harm. Hazardous drinking is when alcohol consumption is greater than 21 units of alcohol / week in men, and 14 units of alcohol / week in women. Daily limits are 8 / 6 units.
1.6.2	**Harmful drinking** – people drinking above "sensible" levels and experiencing harm.
1.6.3	**Alcohol dependence** – people drinking above "sensible" levels and experiencing harm and symptoms of dependence. In practice the Department of Health indicates that these weekly alcohol intake levels are >50 units / week in men, and >35 units / week in women.

1.7	Binge drinking
1.7.1	Binge drinking is what happens when someone drinks the weekly recommended level of alcohol units – or more – in one go, i.e. harmful or hazardous drinking. • Men – the limit is 28 units of alcohol per week. • Women – the limit is 21 units of alcohol per week. Table 1 illustrates some examples of popular alcoholic drinks, and gives the number of units of alcohol for each. For men the Government recommends a maximum of 3 to 4 units per day, for women 2 to 3 units per day. More information may be found on the alcohol and units at the website http://www.drinkaware.co.uk/

Table 1

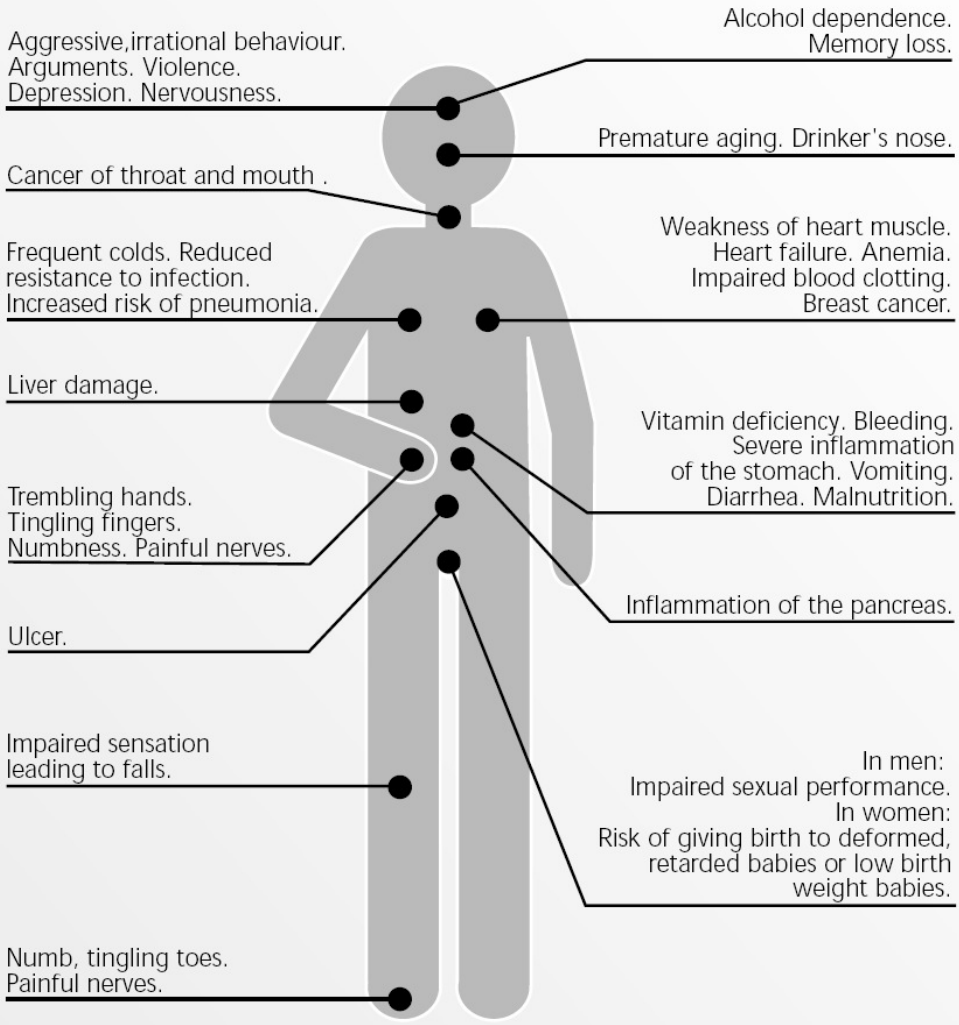
Popular drinks – and the number of units of alcohol in them

Number of units of alcohol	Drinks
1	1 single measure of Bell's whisky (25ml, 40%)
1.2	1 half pint of Fosters lager (4%)
1.5	1 small glass of red wine (125ml, 12%)
3	1 pint of Stella Artois (5.2%)
9	3 pints of Stella Artois
9	1 bottle of red wine (70cl, 12%)
11.5	5 pints of Fosters lager
13	4 bottles of Vodka Kick (275ml / 4%)
26.3	1 bottle of Smirnoff Red vodka (70cl / 37.5%)
26.5	2 litres of White Lightening cider (7.5%)
27	9 pints of Stella Artois

1.7.2	Binge drinking can lead to: • Unacceptable and violent behaviour. • Alcohol poisoning, coma and sometimes death. Passing out somewhere can lead to hypothermia or assault. • Risk of seizures, particularly if a person experiences withdrawal symptoms when suddenly stopping after continuous drinking over a few days. Those close to binge drinkers can suffer abuse and violence. They may also live in fear and confusion. Furthermore, binge drinking can become a very expensive habit. The body and brain develop a tolerance to alcohol, so a person needs to drink more to get the same effect.
1.7.3	The following are some of the effects a binge drinker may experience: • People close to the drinker, telling the drinker about it. • Having days off work due to hangovers. • Having fights or arguments or trouble with the Police after drinking. • Being able to drink more than other people in one session. • Being unable to imagine living without alcohol. • Feeling depressed, guilty or in a low mood after drinking. • Spending a lot of money on alcohol. • Finding it difficult to stop drinking once started.
1.8	Figure 1 illustrates the large variety of health problems associated with alcohol use. Although many of these medical consequences tend to be concentrated in persons with severe alcohol dependence, even the use of alcohol in lower amounts is a risk factor for accidents, injuries, and many social problems.

Figure 1

Effects of High-Risk Drinking



High-risk drinking may lead to social, legal, medical, domestic, job and financial problems. It may also cut your lifespan and lead to accidents and death from drunken driving.

Extract from The Alcohol Disorders Identification Test, Guidelines for Use in Primary Care, World Health Organisation. 2001.

1.9	Derbyshire County Primary Care Trust[2], as commissioners of alcohol treatment services, will be influenced by the *Alcohol Harm Reduction Strategy,* the *Choosing Health* white paper, the *Alcohol Needs Assessment Research Project (ANARP), Alcohol Misuse Interventions: Guidance on developing a local programme of improvement* and *Models of care for alcohol misusers.* Commissioners will also be influenced by demand for alcohol treatment services in Derbyshire, and by the capacity of service providers to deliver robust programmes of alcohol treatment services. Commissioners should also be influenced by the views of Derbyshire's users of alcohol treatment services. All of these issues are considered in the review report. The role of the Derbyshire Drug and Alcohol Action Team (DAAT) is also examined.
1.10	The main providers of Derbyshire Tier 2 and Tier 3 alcohol treatment services are: • Derbyshire Mental Health Service NHS Trust, through the North Derbyshire Community Alcohol Team, based in Chesterfield Royal Hospital (Tier 3) and the Substance Misuse Team, based in Unity Mill, Belper (Tier 2 and Tier 3 services). • North Derbyshire Alcohol Advisory Service, based in Chesterfield (Tier 2 and Tier 3 services). Definitions of Tier 2 and Tier 3 interventions are set out in Table 2.

[2] Derbyshire County Primary Care Trust came into being on 1 October 2006 – replacing six separate, but collaborative, Derbyshire Primary Care Trusts. The County Trust has a new Chairman, Chief Executive, Board and senior managers.

Table 2 – Definitions of Tier 2 and Tier 3 interventions

Tier 2 interventions: open access, non-care-planned, alcohol-specific interventions

Tier 2 interventions include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.

Tier 3 interventions: community-based, structured, care-planned alcohol treatment

Tier 3 interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.

Extract from Models of care for alcohol misusers (MoCAM). Department of Health. June 2006.

1.11	Historically, there have been different funding regimes in different parts of Derbyshire. In the North of the County, Tier 2 and Tier 3 services have been funded by the North Derbyshire Primary Care Trusts[3] and Derbyshire County Council. During 2005/2006 and 2006/2007, additional funding for criminal justice projects has been provide by North Derbyshire community safety programmes, the Derbyshire DAAT and North Derbyshire PCTs. In the South of the County, Tier 3 services have been funded by the South Derbyshire Primary Care Trusts[4]. No funding provision has been made on a recurrent basis for Tier 2 services. For 2006/2007, the National Treatment Agency has agreed that funding for an alcohol alone Tier 2 service can be met from 2005/2006 Pooled Treatment budget underspends. This means that there is no identified budget provision for the continued delivery of Tier 2 services across South Derbyshire from April 2007.

[3] North Derbyshire Primary Care Trusts – Chesterfield PCT, High Peak and Dales PCT and North Eastern Derbyshire PCT

[4] South Derbyshire Primary Care Trusts – Amber Valley PCT, Derbyshire Dales and South Derbyshire PCT and Erewash PCT

1.12	The views of clients of Derbyshire Tier 2 and Tier 3 treatment providers have been sought as part of the review process. Patient and public involvement is considered an essential feature of service improvement. The review team invited Derbyshire Voice and the Swadlincote Alcohol Self Help Group to participate in the review, as well as clients of the Derbyshire Mental Health Services NHS Trust and North Derbyshire Alcohol Advisory Service.
1.13	Members of the Healthier Communities Improvement and Scrutiny Committee who were involved in the review are listed in Appendix 2.

2.	**Executive summary and recommendations**
2.1	The Commissioning Alcohol Treatment Services in Derbyshire review sought to • Identify the current and future accountabilities and responsibilities for the commissioning and delivery of Tier 2 and Tier 3 alcohol treatment services across Derbyshire, and • Make recommendations in relation to the future commissioning and delivery of Tier 2 and Tier 3 alcohol treatment services in Derbyshire.
2.2	In undertaking the review, County Councillors wanted to: • Seek a better understanding of roles and responsibilities of NHS organisations and local authorities in commissioning and providing alcohol treatment services in Derbyshire. • Seek a better understanding of the funding streams for alcohol treatment services across Derbyshire, and in particular any differences in provision of services across the County. • Seek a better understanding of needs of users and potential users of alcohol treatment services, in particular Tier 2 and Tier 3 services. • Influence the delivery of alcohol treatment services, through 2007/2008, and onwards.
2.3	Having considered all of the available information and evidence the Member Task Group identified a number of ***Key Issues***. There are nineteen Key Issues and all inform the Review Recommendations. Key issues cover: • Commissioning and funding, including the Invest to Save philosophy, a pooled treatment budget, a Health Needs Assessment. • Service delivery, access to services and transitional arrangements (from young people to adulthood). • Community Strategy, Local Area Agreement, the planned Alcohol Harm Reduction Strategy and other plans. • Patient and Public Involvement. • Social inclusion services, such as access to learning, access to education etc.

2.4 RECOMMENDATIONS

RECOMMENDATION 1 – Commissioning services and funding	
Derbyshire County Primary Care Trust should:	
(a)	**Maintain, at least, the current level of Tier 2 and Tier 3 alcohol treatment services across Derbyshire in 2007/2008, including provision of Tier 2 and Tier 3 services arising from Alcohol Treatment Orders.** **Provide sufficient resources so that immediate access to Tier 2 or Tier 3 alcohol treatment services is available.** **A decision on this issue should be made urgently so that service providers can effectively plan services for 2007/2008, with the minimum impact of existing clients.** **(There is a link to recommendation 2 in relation to the introduction of a Pooled Treatment Budget from 1 April 2007).**
(b)	**Further develop generic Tier 2 and Tier 3 alcohol treatment services across Derbyshire during 2007/2008, in line with the outcomes of the Heath Needs Assessment currently underway.** **(There is a link to recommendation 2 in relation to the introduction of a Pooled Treatment Budget from 1 April 2007).**
(c)	**Urgently undertake a review of the savings accrued to the former Derbyshire Primary Care Trusts as a result of the introduction of a Tier 2 alcohol treatment service in South Derbyshire on 1 April 2007.** **The Committee recognise that a detailed appraisal may not be possible, but this information should influence future commissioning and Invest to Save plans.**

RECOMMENDATION 2 – Strategies and policies	
The Derbyshire DAAT should:	
(a)	**Prepare and implement its' Alcohol Harm Minimisation Strategy as soon as practically possible, and at least by 1 April 2007.**
(b)	**Encourage all relevant agencies and organisations to adopt the aims and objectives of the Strategy and to align services against these aims and objectives.** **Agencies and organisations should also be asked to ensure that service planning and target setting is consistent with the Strategy so that they is harmonisation in targets associated with alcohol misuse.**
(c)	**Introduce a Pooled Treatment Budget for alcohol treatment services from 1 April 2007.** **The Committee feel that this would further support the need to better integrate services to support alcohol treatment plans.**
(d)	**Continue to support service providers in relation to transitional issues when young people transfer to adults services.**
(e)	**Continue to support service providers in raising awareness of the existence of Tier 2 and Tier 3 alcohol treatment services.** **The Committee valued the work undertaken by the North Derbyshire Community Safety Partnerships, the North Derbyshire Community Alcohol Team and the North Derbyshire Alcohol Advisory Service in raising awareness of services (*The Usual Suspects initiative)*. This initiative was linked to crime reduction but appropriate services must be in place to manage demand and so avoid increase waiting lists. (There is a link to recommendation 1).**

RECOMMENDATION 3 – Derbyshire County Council	
Derbyshire County Council should ensure that a programme of training is in place so that staff who engage with people who have alcohol misuse issues are identified and referred into appropriate treatment services.	
RECOMMENDATION 4 – Patient and Public Involvement	
(a)	Derbyshire County Primary Care Trust and Derbyshire DAAT should ensure that the views of patients and carers are sought and listened to in relation to the commissioning of alcohol treatment services. The Primary Care Trust should ensure that this issue is reflected in commissioning documents and service level agreements.
(b)	All alcohol treatment service providers should ensure that the views of patients and carers are sought and listened to in relation to the provision of alcohol treatment services.

3.	**Alcohol Treatment Services, strategies, policies and standards – the national and local context**
3.1	In recent times there has been an increased focus on alcohol misuse and its links to poor health and crime, at Government and local levels.
3.2	In 2004, the Department of Health published its vision for improving public health, through ***Choosing Health – making healthy choices easier*.** Alcohol is identified as one of nine areas of concern for the Government. It's alcohol facts sheet identifies that: • Between 15,000 and 22,000 deaths each year are associated with alcohol misuse, mainly from stroke, cancer, liver disease, accidental injury or suicide. • Around 1 million children live in families where one or both parents misuse alcohol. • 5.9 million people in England drink above the Government's recommended daily guidelines on some occasions. • Around 25% of children aged 11 to 15 drink alcohol, and they drink an average of around 10 units per week. • 360,000 incidents of domestic violence are linked to alcohol misuse, around a third of all domestic violence. • Half of all violent crimes are alcohol-related. • Alcohol misuse is associated with 150,000 hospital admissions each year. Around 70% of A&E attendances between midnight and 5am on weekend nights are alcohol-related. The loss to the economy of premature death from alcohol misuse is around £2.4 billion each year.
3.2	In 2004, the Government published its strategy for tackling the problems associated with alcohol misuse. ***The Alcohol Harm Reduction Strategy for England*** puts joint action at the heart of a series of measures which aim to: • Tackle alcohol-related disorder in town and city centres. • Improve treatment and support for people with alcohol problems. • Clamp down on irresponsible promotions by the industry. • Provide better information to consumers about the dangers of alcohol misuse.

3.2.1	The Strategy identified that there were a number of problems with the existing identification, referral and treatment services, such as: • Alcohol problems are often not identified sufficiently early, leading to later financial and human costs. • Health service staff have low awareness of alcohol issues. • There is little information on demand for treatment, the provision of services to meet this demand, or for the current capacity of treatment services. • The structure of alcohol treatment can vary widely, with no clear standards for, or pathways through treatment. • Procedures for referring vulnerable people between alcohol treatment and other services are often unclear.
3.2.2	The Government considers that effective treatment requires that: • Those with alcohol problems are identified and referred to the appropriate services. • Appropriate treatment is available. • Treatment for vulnerable groups covers all their related needs and problems and adequate aftercare is available.
3.2.3	<u>Identification and referral to other services</u>
	The Strategy highlights the need for improving the identification process in the health system, in places such as GP practices, A&E, hospital inpatient and outpatient services, mental health services and ante-natal care. All of these places provide opportunities to establish whether a patient has an alcohol problem and to take action – perhaps screening and a brief intervention.
	Brief interventions are opportunistic, that is they are administered to patients who have not attended a consultation to discuss their drinking. It could be a short conversation with a doctor or nurse to a number of sessions of motivational interviewing. It is the giving of information and advice, encouragement to the patient to consider the positives and negatives of their drinking behaviour, and support and help to the patient if they do decide that they want to cut down their drinking.

	The Strategy also identifies the need to train professionals on alcohol issues. Doctors training may be as little as a few hours on alcohol issues over their five-year training period. This can lead to issues around basic awareness of alcohol misuse and a lack of clarity on the next steps.
	People's alcohol problems can also be picked up in other non-health settings, such as at pre-school care, at school, further education and high education institutions, by the Connexions Service, in the workplace, by social services and in the criminal justice system.
3.2.4	Treatment
	The effectiveness of treatment is dependent on the degree of motivation and type of problem. Different individuals will respond to different types of treatment. Treatment needs to be tailored to an individual's circumstances, needs and motivation, and include: • Community structured counselling – motivational therapy, coping / social skills training, behavioural self-control training, marital / family therapy. • Community detoxification – usually in a home setting, with the support of a GP, a nurse, or an alcohol treatment worker. • Specialised residential services. • Self help groups.
	The Strategy acknowledges that there is very little information on the demand for, or provision of, alcohol treatment services. Also, no information is routinely collected on issues such as: • The numbers of people entering treatment each year. • The proportion of successful outcomes.
3.2.5	Treatment and aftercare for vulnerable groups
	The Strategy acknowledges a risk that alcohol treatment for vulnerable groups, such as those with a serious mental illness, or those who are homeless, may fail due to a lack of co-ordination of treatments and services.
	The Supporting People programme offers vulnerable people, including those with alcohol-related problems, the opportunity to improve their quality of life by providing a stable environment which enables greater independence.

3.3	The ***Alcohol Needs Assessment Research Project (ANARP)*** published in November 2005 is the first English needs assessment. Its' main purpose was to measure the gap between the demand for and provision of specialist alcohol treatment services in England. It presents information at national and regional level.
3.3.1	Key findings of ANARP included: • **Alcohol dependence is considerably more prevalent than drug abuse.** • **Drug Action Team professionals believe the harm resulting from alcohol misuse is far greater than from drug misuse.** • **People with alcohol dependence are heavy consumers of health services, but are not often identified as having alcohol dependence.** • 38% of men and 16% of women (age 16 to 64) have an alcohol use disorder (26% overall) – equivalent to 8.2 million people in England. • 21% of men and 9% of women are binge drinkers. • 6% of men and 2% of women are dependent drinkers, an average of 3.2% - 1.1 million people with alcohol dependence nationally. • GPs tend to under-identify younger patients with alcohol use disorders compared with older patients. • Though GPs were identifying a need for treatment, they were not referring since they perceived difficulty in accessing treatment services due to waiting lists, and patient preference not to engage in specialist treatment. • Research with DAT professionals identified a gap between the provision of alcohol treatment services and need or demand. • The largest proportion of referrals to alcohol agencies being self referrals (36%) followed by GP / primary care referrals (24%). • Estimated annual spend on specialist alcohol treatment is £217 million. • Average waiting time for assessment was 4.6 weeks.

3.3.2	Regionally, the ANARP study showed differences against the national averages. The incidence of hazardous or harmful drinking the East Midlands is slightly higher than the national average, with 24% of the 16 to 64 population recorded as hazardous or harmful drinkers, compared to a national average of 23%. However, the prevalence of drinkers with an alcohol dependence is less than the national average, with 1.6% of the 16 to 64 population recorded as alcohol dependent compared to a national average of 3.6%. Overall, the numbers are similar between the East Midlands region and England.
3.3.3	Data is not available for counties or unitary authorities. This means that there is no specific data for Derbyshire. However, the Department of Health expects local areas to use ANARP findings to influence benchmarking of their local services against services in other areas.
3.3.4	Professor Colin Drummond, a member of the team who led the ANARP research, has commented on policy implications for agencies and organisations responsible for commissioning alcohol treatment services. Issues are set out in Table 3.

Table 3
Summary of some of the policy implications of ANARP

Potential for improvement in screening, identification and referral • People with alcohol dependence are heavy consumers of health services • There are opportunities to increase identification and referral activity across primary and secondary health care, and in other agencies e.g. criminal justice & social services. • Need for development and implementation of systematic referral criteria / integrated care pathways for alcohol use disorders.
Better prospective data collection of prevalence of alcohol treatment disorders • In the general population. • In primary and secondary care (including general practice, A&E departments and general hospitals) • Alcohol treatment agencies should be incorporated into the National Drug Treatment Monitoring System.
Assessment of alcohol-related need and the impact of alcohol policies • A central monitoring system for indicators of alcohol related harm and prevalence of alcohol use disorders would assist in future needs assessment and service planning.
Methods of improving access to alcohol treatment
Methods of increasing levels of screening, identification, intervention and referral • Across primary care, secondary care, criminal justice and social care. • Include the impact of screening initiatives on demand for specialist alcohol treatment.
Methods of engaging people with alcohol dependence in treatment • Impacts of assertive outreach and intensive case management.

3.4	Also in November 2005, the Department of Health published guidance on developing and implementing alcohol treatment programmes that can improve the care of hazardous, harmful and dependent drinkers. ***Alcohol Misuse Interventions: Guidance on developing a local programme of improvement*** provides further detail on the policy context of the *Alcohol Harm Reduction Strategy* and the *Choosing Health* white paper.
3.4.1	This Guidance suggests practical steps that Primary Care Trusts can take to improve the identification and treatment of individuals whose drinking is potentially hazardous, is causing harm to themselves or others or arises from a dependence on alcohol.

3.4.2	Such steps might include:
	• Assessment of local need, current provision and levels of investment for screening and brief interventions and services for dependent drinkers across the local health and social care economy.
	• As part of their assessment of the entire pathway, consider whether screening an brief interventions are offered to hazardous and harmful drinkers who:
	  o Attend primary care as a new registration or with a pre-existing condition where alcohol may contribute to the harm, or are perceived by the GP as being at an increased risk of developing health conditions because of excessive conditions.
	  o Attend other hospital health care settings, e.g. GUM clinics or fracture clinics.
	  o Attend a non-NHS service, e.g. in a criminal justice setting.
	• Publish a guide to local services.
	• Use opportunities available within the new General Medical Services contract to deliver enhanced services and a range of models of prevention to meet need.
	• Agree explicit criteria for referral and treatment thresholds and trigger points within service level agreements and contracts. This includes involving service users more directly in decisions about interventions and treatment.
	• Have appropriate contracting and monitoring arrangements in place at PCT level to influence the impact on identified areas of NHS service demand and access.

	• PCTs should take account of the different needs and inequalities within the hazardous, harmful and dependent drinkers population, in respect of area, socio-economic group, ethnicity, gender, disability, age, faith, and sexual orientation, on the basis of a systematic programme of health equality audit and equality impact assessment. • Successful modernisation and improvement depends on PCTs, local authorities, other local partners, service users and service providers working together. • Match provision with need.
3.5	**Models of care for alcohol misusers (MoCAM)**
3.5.1	Published in June 2006, the Models of care for alcohol misusers is the Department of Health's best practice guidance on a framework for commissioning and providing interventions and treatment for adults affected by alcohol misuse. It describes a four tier system of stepped care for alcohol misusers.
3.5.2	MoCAM will assist in:
	• Improving practice in the commissioning and delivery of alcohol treatment services. • Developing integrated local treatment 'systems', through the tiered framework of provision. • Improving the effectiveness of screening and assessment. • Improving care planning in structured treatment. • Developing integrated care pathways ('alcohol treatment pathways'). • Meeting national quality standards by providing key quality criteria for the commissioning and provision of services for alcohol misusers. • Identifying appropriate interventions and specific treatment options that could be commissioned to meet local need.
3.5.3	The four tiers of interventions are set out in Appendix 1.

3.6	**Alcohol Strategies in Derbyshire**
3.6.1	**Derbyshire Community Strategy 2006/2009**
	The Derbyshire Community Strategy is the overarching strategy for public services in Derbyshire. Its aim is *"To improve the quality of life of all people by making Derbyshire a safer, healthier and more sustainable place to live, work and learn".* The Strategy is organised into four themes mirrored in the Local Area Agreement and reducing the harm caused by alcohol is identified as a key priority.
3.6.2	**Derbyshire's Local Area Agreement (LAA)**
	The LAA *"Working together for a better Derbyshire"* is one of the main funding tools support mainstream provision for delivering priorities set out in the Community Strategy. The **LAA** identifies a specific outcome measure within the Healthier Communities and Older People policy block relating to alcohol misuse, o *Alcohol harm minimisation – reduce the number of people harmed directly or indirectly as a result of alcohol consumption.* **The baseline and target for achieving improvements against this measure will be set during 2007/2008. This outcome measure is directly linked to increased life expectancy. However, a reduction in alcohol consumption will also positively impact on other LAA health related targets, for example heart disease.** **The Safer and Stronger Communities policy block includes a target relating to reduce crime, the fear of crime and anti-social behaviour *"to achieve a 5% reduction in crime from 2004/2005 baseline by March 2008".*** **The April 2006 to September 2006 LAA performance report illustrates that this target is not being met, and that *"the main problem areas continue to be the town centres on Friday and Saturday nights, with links to alcohol"*.** **Other LAA policy blocks are Children and Young People and Sustainable Communities.**

	<u>KEY ISSUE 1 – driving recommendation 1</u> **We welcome the development of baseline data and targets in 2007 for the *Alcohol Harm Minimisation* outcome measure.** **We believe that this measure better placed in the Healthier Communities and Older People policy block, since it relates to a health outcome – *Increased life expectancy.*** **However, we also recognise the link between alcohol misuse and crime identified in the Safer and Stronger Communities policy block target in relation to crime, the fear of crime and anti-social behaviour, and the potential for robust and effect alcohol treatment services to positively impact on the crime outcome measure.** **We believe that continued and further investment in alcohol treatment services, inside and outside the Local Area Agreement, by Derbyshire County Primary Care Trust, Derbyshire County Council and other public sector organisations in Derbyshire, will positively contribute to the aims of Derbyshire Community Strategy.**
3.6.3	**2007/2008 NHS Local Delivery Plan**
	Local Delivery Plans are in two parts. First, there is a narrative describing the strategic framework, the approach to key targets and the main risk management strategies. Second, there are a series of 'output schedules', which show the planned trajectories towards achieving the main targets of the NHS Plan. These trajectories show, for example, the number of people in each PCT who will have access to smoking cessation services, or the number waiting more than 6 months for treatment in each quarter. The Review team has not received any information from NHS organisations relating to existing or future Local Delivery Plans or the strategic priority given to alcohol treatment services.
	<u>KEY ISSUE 2- driving recommendation 1</u> **We want Derbyshire County Primary Care Trust to be explicit about its priorities for maintaining and further improving Tier 2 and Tier 3 alcohol treatment services in Derbyshire.**

3.6.4	**Derbyshire County Council – The Council Plan 2005/2009**
	Priority 31 of the **Council Plan** is *to reduce alcohol and drug misuse and the harm caused by drugs.* However, currently there are no specific Council targets relating to alcohol misuse or support for people with an alcohol dependency.
	KEY ISSUE 3 – driving recommendation 2 **We feel that Derbyshire County Council should further develop Priority 31 so that at least the aim is amended to *"to reduce alcohol and drug misuse and the harm caused by drugs and alcohol".*** **We feel that it would be appropriate for the County Council to explore targets and activities in partnership with the DAAT.**
3.6.4	**A Derbyshire Joint Agency Alcohol Harm Reduction Strategy**
	The Derbyshire DAAT is preparing an Alcohol Harm Reduction Strategy for 2007 onwards. The aim of the Strategy is to provide Countywide direction for the commissioning and delivery of alcohol treatment services, as well as identifying robust preventative measures (education and also raising awareness of the effects of alcohol misuse) and effective enforcement. Plans are in place to implement the Strategy in Spring 2007.
	KEY ISSUE 4 – driving recommendation 2 **We welcome the introduction of an Alcohol Harm Reduction Strategy for Derbyshire, developed by a range of agencies through the DAAT.** **We hope that our work on this Review will influence the "treatment" element of the Strategy.**

3.6.5	**Every Child Matters**
	One of the five outcomes for children and young people in the Every **Child Matters** ethos is *BE HEALTHY.* In relation to children and young people, one of the five aims of a *Be Healthy* outcome is to have a healthy lifestyle. A target is *average alcohol consumption.* One of the inspection criteria includes "*children and young people are discouraged from smoking and substance abuse (including drugs, volatile substances and alcohol) and are supported in giving up.* The Local Area Agreement includes a target relating to increasing the number of problematic drug users (under 18) in treatment programmes by 50% between 2004 and 2008. The target includes drug and alcohol misusers and one of the aims is to increase the numbers entering Tier 3 treatment services.
	KEY ISSUE 5 - driving recommendation 2 **The Local Area Agreement outcome measure is aimed at increasing the number of problematic drug users, some of whom may have an alcohol misuse issue too.** **We feel that the Local Area Agreement and Derbyshire County Council be aware of the need to improving outcomes for young people with an "alcohol alone" issue.**

4.	**<u>Alcohol misuse and links to community safety and the Criminal Justice system</u>**
4.1	**Alcohol misuse contributes significantly to crime.**
4.2	The ***Alcohol Harm Reduction Strategy for England*** reports that:

	• Alcohol misuse is a major contributor to crime, disorder and anti-social behaviour, with alcohol-related crime costing society up to £7.3 billion per annum.
	
	• Areas of concern include:
	  ○ Alcohol-related disorder and anti-social behaviour in towns and cities at night.
	  ○ Under-age drinking.
	  ○ Crime, disorder and anti-social behaviour – often caused by repeat offenders.
	  ○ Domestic violence.
	  ○ Drink-driving.
	
	• Better identification of alcohol problems and referral to alcohol services is required.

4.3	**The National Probation Service**
4.3.1	In May 2006, the National Probation Service published guidance *Working with Alcohol Misusing Offenders – a strategy for delivery.* The Strategy complements the Alcohol Harm Reduction Strategy for England and the Models of Care for Alcohol Misusers (MoCAM) and related Department of Health work on Alcohol Misuse.
4.3.2	The Strategy sets out some of the underlying issue between alcohol misuse and crime. Alcohol can act as a disinhibitor or is used as an excuse or can result in crime because an individual has a drinking problem. Alcohol misuse features predominantly in violent offences, including domestic violence, and is often associated with anti-social behaviour. Those who drink to excess are more likely to offend that those who don't.

4.3.3	The Strategy documents a recent study which demonstrated that: • 37% of offenders had a current problem with alcohol use. • 37% of offenders had a problem with binge drinking. • 47% of offenders had misused alcohol in the past. • 32% of offenders had violent behaviour related to their alcohol use. • 38% of offenders were found to have a criminogenic need relating to alcohol misuse, potentially linked to their risk of reconviction. Further research showed that: • 73% of domestic violence cases involved consumption of alcohol before the offence. • 62% of domestic violence case "featured" alcohol. • 48% of these convicted domestic violence offenders were alcohol dependent.
4.3.4	Amongst the aims and objectives of the Strategy are the reduction of re-offending and alcohol related harm through: • Improving the advice and information provided to offenders about the risks of alcohol misuse and about help that is available locally. • Developing and promoting the delivery of evidence-based interventions to meet the needs of a full range of alcohol-using offenders. The National Probation Service has identified the targeting, screening, referral and assessment of offenders with alcohol issues as a priority area. Local probation services should be working with their local drug and alcohol action teams to develop local systems of screening and assessment, and identifying those individual offenders who need onward referral to these systems. Furthermore, local probation service teams should be providing "brief interventions" to alcohol misusing offender – sharing information, brief advice and support for behavioural change to help encourage responsible drinking and reduce risks to health.

	Local probation services should also influence their DAAT teams to ensure that a comprehensive assessment of local need is identified, and that the DAAT is commissioning appropriate services to meet those needs. Probation services can also provide information on the extent of alcohol-related offending in their area, and bring it to the attention of Community Safety Partnerships.

4.4	**The National Probation Service – Derbyshire**	
4.4.1	The Derbyshire Probation Service has an active role on the Derbyshire Drug and Alcohol Team, being represented on the main Board and also providing the Chair for the Alcohol Joint Commissioning Group.	
4.4.2	The Derbyshire Probation Service is primarily responsible for supervising offenders placed under a Community Order by the Courts. A Community Order replaces previous community sentences, and may include at least one out of twelve possible requirements, covering:	
	• Alcohol treatment	• Residence
	• Unpaid work	• (Specified) Activity
	• Supervision	• Prohibited activity
	• Programme	• Exclusion (from a place)
	• Drug rehabilitation	• Curfew
	• Mental health treatment	• Attendance centre (offender under 25)
4.4.3	The process involving an alcohol treatment requirement (note that there may be other requirements in an offender's Community Order too) is set out: • Offender arrested and charged. • Appears at Court (pleads or if found guilty. • Court requests a report to assist sentencing. • Standard delivery report. • Fast delivery report • Offender manager completes an assessment • Requests ATR assessment. • Consider" ideal" combination of requirements.	

4.4.4	An Alcohol Treatment Requirement is part of the Criminal Justice system, and may be made under Section 212 of the Criminal Justice Act 2003. Table 4 sets out some information about alcohol treatment requirements. Since ATRs involve people with an alcohol dependency they are classified as a Tier 3 intervention. Alcohol Treatment Requirements are not funded by the Courts or the National Probation Service. Funding must be sought locally. The North Derbyshire Alcohol Advisory Service has provided information that it received £30,000 from the Derbyshire DAAT for the provision support to ATRs in North Derbyshire. This non-recurrent funding was provided by Derbyshire Constabulary, the National Probation Service – Derbyshire and the Derbyshire DAAT. It will have to be renegotiated for 2007/2008 onwards. More information on Alcohol Treatment Requirements and their impact on local service delivery may be found in section 6.3.14, 6.3.15 and 6.5.8 and Table 12.

Table 4 - Alcohol Treatment Requirements

An Alcohol Treatment Requirement (ATR) may be imposed on an offender, as part of their Community Order, under Section 212 of the Criminal Justice Act 2003.

The alcohol treatment requirement provides access to a tailored treatment programme with the aim of reducing drink dependency. The requirement can last between six months and three years.

Before issuing an Alcohol Treatment Requirement, the Court must be satisfied that:

- **The offender is dependent on alcohol, and may benefit from treatment;**
- **Arrangements have or can be made for the treatment to take place;**
- **The requirement is suitable for the offender; and**
- **The offender expresses willingness to comply with the requirement and work at reducing their addiction.**

An Alcohol Treatment Requirement can be made part of a Community Order or a Suspended Sentence Order for a minimum of six months and a maximum of 3 years.

To impose an Alcohol Treatment Order the Court does not have to be satisfied that the offender's dependency on alcohol caused or contributed to the offence(s) for which he or she has been convicted.

The Alcohol Treatment Requirement became available to Courts as a sentencing option for offences committed on or after 4 April 2005 by offenders aged 18 or over.

If there are two "did not attends" recorded by the treatment provider then the offender will return to Court (after the 1st DNA a Warning will be given, the 2nd is a Breach of the Order).

The Court must deal with the offender, and may,

- **Impose more onerous requirements.**
- **Revoke the Community Order and re-sentence.**
- **Revoke the Community Order and imprison – whether or not the original offender was imprisonable.**
- **Commit to Crown Court if the Order was made by a Crown Court.**

The Court can neither fine nor take no action.

4.4.5	Derbyshire Probation Service supervises about 4500 adult offenders every year, approximately 2100 of these offenders live in the County area. Analysis of Derbyshire offender data in September 2006 identified that for 43% of offenders alcohol misuse was identified as relating to their offending behaviour. The picture is consistent across districts in the County. This means that, in any given year, approximately 900 offenders' experience alcohol misuse. The evidence linking alcohol misuse and crime is strong. Alcohol is a disinhibitor off crime, particularly sex crime. Therefore the Probation Service is keen to target offenders with an alcohol misuse issue, and to refer them to the appropriate services, either voluntarily or through Alcohol Treatment Requirements. If no or limited alcohol treatment services were available, it would have an adverse impact on crime, and victims of crime – particularly so as alcohol misuse influences violent crime.

	Probation officers also deliver Tier 1 interventions, and some elements of Tier 2 interventions, such as providing advice and information about problematic drinking, supporting offenders in maintaining drink diaries, and addressing changes in offender's behaviour. However, Probation Service staff do not carry out assessments – these are undertaken by specialist alcohol treatment services.

4.4.7	The Derbyshire Probation Service also participates in a regional forum with other East Midlands Probation Service areas. A recent report *Changing Ways: A delivery plan to reduce re-offending in the East Midlands* identifies Alcohol as a main issue – alongside Accommodation and support, Education Training and Employment, Health, Drugs, Finance, Benefit and Debt, Children and Families of Offenders, and Attitudes, Thinking and Behaviour. *Changing Ways* offers examples of best practice projects across the region, and summarises emerging policy themes and key documents.
4.5	**Derbyshire County Council – Community Safety**
4.5.1	Derbyshire County Council's Community Safety Team also has a detailed knowledge of the relationship between alcohol misuse and criminal activity and anti-social behaviour.
4.5.2	National research demonstrates a relationship between alcohol misuse and crime, and there is some local data which reinforces that message.
4.5.3	An audit of Crime and Disorder in Derbyshire, over the period 2001-2004, identified that: • 65% of violent crime takes place at night time. • 30% of violent crime takes place on Friday and Saturday nights. • 40% of violent crime takes place between 6pm on Saturday evening and 6am on Sunday morning. • Research undertaken in Bolsover and South Derbyshire, by the Safer Derbyshire Research and Information Team found that there are proportionately more violent incidents around licensed premises compared with the population distributions.

	• The research also concluded that postcodes with licensed premises have on average three to four times the number of violent incidents than postcodes without licensed premises. Peak times are weekend nights and early mornings, associated with traditional drinking hours and pub closing times.
	• Estimated costs of violent crime to Derbyshire over the period 2001 to 2004 were £179.2 million.
	• There is evidence to suggest that there are links between domestic abuse and substance misuse, both alcohol and drugs.
	• There are links between alcohol and anti-social behaviour.
	• Two groups of people are particularly likely to raise their risk of harm,
	  ○ Binge drinkers, under 25 years, have high levels of attendance at A&E departments related to alcohol.
	  ○ Chronic drinkers, over 30 years, increased risk of a variety of health harms.

4.5.4	An analysis of violent crime in Derbyshire during the period January 2006 to August 2006 demonstrates a strong association between alcohol and violent offending. • The analysis identifies a clear link between binge drinking and an increased likelihood of violent offending. • The top 13 Derbyshire Wards for violent crime are all in town centres. • The peak time for wounding is Friday and Saturday, from 8pm to 3am. • The higher the number of licensed premises in an area, the higher the number of reported wounding. • Victims have the same profile as offenders, 18 to 24 years. • The chance of becoming a victim also increases with the greater volume of alcohol consumed.
4.5.5	Chesterfield, North East Derbyshire and Bolsover Community Safety Partnerships have worked with the North Derbyshire Alcohol Advisory Team (NDAAS), the North Derbyshire Community Alcohol Team and Unit 10 (a Chesterfield based youth service project) on a project to produce advice cards.

	Cards with a design based on the 1995 film *The Usual Suspects* were placed in Health Centres and Council Offices and shared with members of Pub Watch and Neighbourhood Watch groups. NDAAS reported an increase in referrals of up to 55%, with new clients reporting that they had accessed NDAAS contact details from a card. The project linked into the work delivered by NDAAS funded by the North Derbyshire Community Safety Partnerships. See section 6.3.16 and Table 13.
	KEY ISSUE 6 – driving recommendation 1 **Derbyshire County Council's Community Safety Team has stated that there are links to violent crime and anti-social behaviour and alcohol misuse. Given this, it is likely that if Tier 2 alcohol treatment interventions are withdrawn from April 2007, there will be an adverse impact on Derbyshire's communities, families and individuals.** **During the event on 31 October 2006, the Member Task Group asked "*If there are no Tier 2 alcohol treatment interventions planned in South Derbyshire from April 2007, where will patients go?"*** **Paul Yates of the National Probation Service commented that in the event of a cessation in the delivery of Tier 2 services it is likely that *"offenders will offend more". (see section 8.13)*** ***We believe that there is a link between the provision of alcohol treatment services and crime and disorder.***

5.	**Commissioning Alcohol Treatment Services in Derbyshire**
5.1	**Derbyshire County PCT**
5.1.1	Derbyshire County Primary Care Trust was constituted on 1 October 2006. The new organisation replaces six smaller primary care trusts, though has the same area of geographic spread. It serves the population of Derbyshire, including those living in Amber Valley, Bolsover, Chesterfield, Derbyshire Dales, Erewash, High Peak, North East Derbyshire and South Derbyshire district council areas. It does not include the population of Glossopdale – covered by Tameside and Glossop Primary Care Trust.
5.1.2	Derbyshire County PCT has a new Chair and Board and Chief Executive and senior management team.
5.1.3	Historically, responsibility for the commissioning of alcohol treatment services has rested with individual primary care trusts, but in practice services have been commissioned on a North and South Derbyshire basis. Chesterfield PCT led the commissioning arrangements for North Derbyshire, and Amber Valley PCT led the commissioning arrangements for South Derbyshire.
5.1.4	Tables 5 and 6 summarise information shared by the former Chesterfield PCT on behalf of the North Derbyshire commissioning arrangements, and information provided by the new Derbyshire County PCT on the previous commissioning arrangements in South Derbyshire. We recognise that some or all of these arrangements may change over the coming months as a result of the constitution of the new Derbyshire County PCT.

Table 5 – Commissioning information from Chesterfield PCT

• Anne Dray, former Chief Executive of Chesterfield PCT, was the Derbyshire PCTs Chief Executive representative on the Derbyshire Drug and Alcohol Action Team Board.
• The commissioning of alcohol treatment services is a responsibility of each Primary Care Trust in North Derbyshire. (This responsibility now rests with Derbyshire County Primary Care Trust).
• The PCTs are in discussion with the Chair of the Drug and Alcohol Action Team (DAAT) in relation to responsibility for commissioning arrangements being transferred to the DAAT. The main reason for this is that the DAAT is a specialist resource for commissioning substance misuse treatment services.
• The DAAT is developing service specifications for the North Derbyshire Alcohol Advisory Service and the North Derbyshire Community Alcohol Team. A number of performance output targets are being incorporated into the specifications, including unit costings for interventions on a client basis.
• There is ambition to align existing alcohol treatment services resources in PCT budgets in relation to specific Tier 2 and Tier 3 alcohol treatment services.
• The North Derbyshire Community Alcohol Team, which provides a home detoxification service, is funded as part of a block contract with Derbyshire Mental Health Services NHS Trust. It is based at Chesterfield Royal Hospital.
• Tier 4 inpatient specialist alcohol treatment services are provided by Chesterfield Royal Hospital NHS Foundation Trust, as part of a generic commissioning arrangement. Diagnostic codes have not been examined, nor have costs been calculated.
• The PCTs also commission emergency and elective care services from a number of other Trusts that will have an element of inpatient provision for conditions relating to alcohol misuse. This, too, has not been quantified or costed.
• A Screening service in the A&E Department of Chesterfield Royal Hospital is being developed.

• **A liaison service between the North Derbyshire Community Alcohol Team and wards in Chesterfield Royal Hospital is also being developed.**
• **The North Derbyshire Alcohol Advisory Service (NDAAS) is commissioned to deliver drop-in sessions and training with GP practices to ensure that they can offer brief interventions. NDAAS also provides structured counselling.**
• **Structured day programmes are not available for alcohol clients in North Derbyshire.**
• **Residential rehabilitation is commissioned through the community care budget, held by Derbyshire County Council.**
• **Funding for clients with complex needs (through the Supporting People programme) has been provided in 2005/2006, and non-recurrent funding has been identified for 2006/2007.**

• **Arising from the *Choosing Health* agenda, an additional £78,000 (recurrently) will be targeted to the agreed priorities of the Alcohol Strategy. This will include:**
  ○ **Further development of the North Derbyshire Community Alcohol Team – including screening and brief interventions work with the A&E Department at Chesterfield Royal Hospital and the liaison service).**
  ○ **Further development of the North Derbyshire Alcohol Advisory Service to support ongoing training for primary care and other Tier 2 practitioners, and some infrastructure investment.**

• **There are current plans to provide ongoing investment in these services to ensure the NDAAS has the capacity to meet the treatment, counselling and structured support needs of people who are identified following Tier 1 training, through the 2007/2008 Local Delivery Plan.**

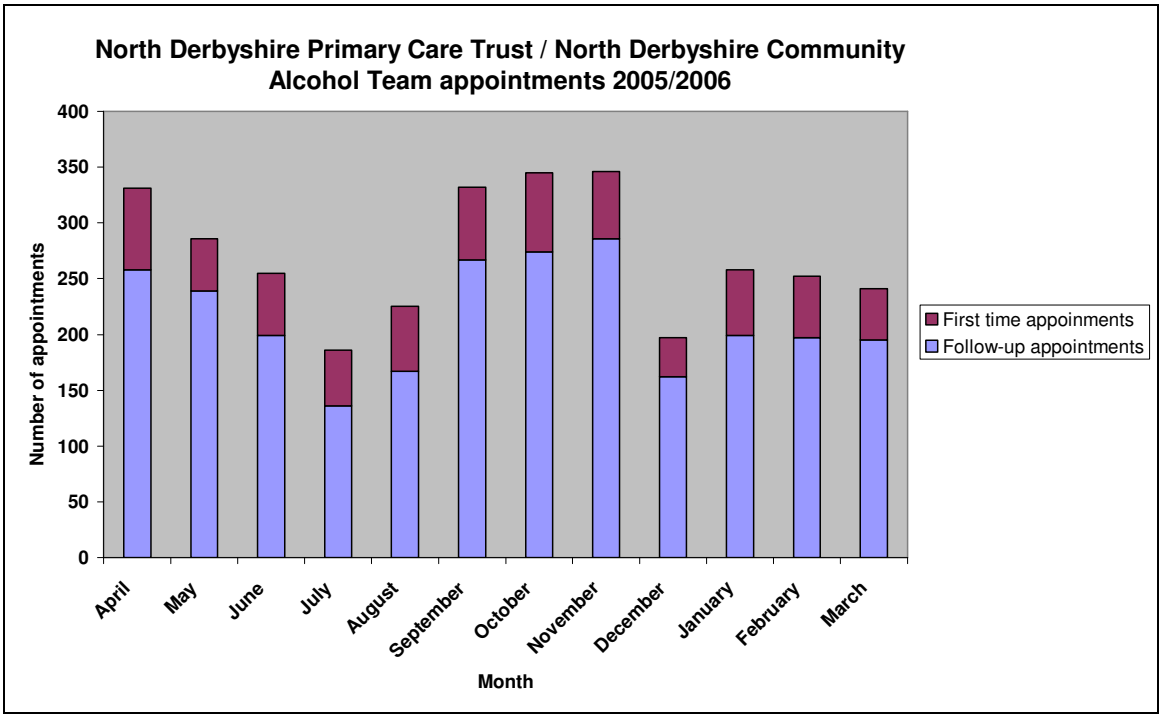
Table 6 – South Derbyshire commissioning information

• Anne Dray, former Chief Executive of Chesterfield PCT, was the Derbyshire PCTs Chief Executive representative on the Derbyshire Drug and Alcohol Action Team Board.
• The commissioning of alcohol treatment services was a responsibility of each Primary Care Trust in South Derbyshire. (This responsibility now rests with Derbyshire County Primary Care Trust).
• The PCTs are in discussion with the Chair of the Drug and Alcohol Action Team (DAAT) in relation to responsibility for commissioning arrangements being transferred to the DAAT. The main reason for this is that the DAAT is a specialist resource for commissioning substance misuse treatment services.
• The DAAT is developing service specifications for the Southern Derbyshire Tier 2 and Tier 3 Alcohol Services (including ATRs). A number of performance output targets are being incorporated into the specifications, including unit costings for interventions on a client basis.
• There is ambition to align existing alcohol treatment services resources in PCT budgets in relation to specific Tier 2 and Tier 3 alcohol treatment services.
• The Southern Derbyshire Substance Misuse Team, which provides a home detoxification service, is funded as part of a block contract with Derbyshire Mental Health Services NHS Trust. It is based at Unity Mill.
• Tier 4 inpatient specialist alcohol treatment services are provided by Derby Hospitals Foundation NHS Trust, as part of a generic commissioning arrangement. Diagnostic codes have not been examined, nor have costs been calculated.
• The PCTs also commission emergency and elective care services from a number of other Trusts that will have an element of inpatient provision for conditions relating to alcohol misuse. This, too, has not been quantified or costed.
• A Screening service in the A&E Department of Derbyshire Royal Infirmary using the nationally recognised FAST assessment tool is being developed.
• Structured day programmes are not available for alcohol clients in South Derbyshire.

• **Residential rehabilitation is commissioned through the community care budget, held by Derbyshire County Council.**
• **Funding for clients with complex needs (through the Supporting People programme) has been provided in 2005/2006, and non-recurrent funding has been identified for 2006/2007.**
• **The alcohol element of the *Choosing Health* funding, which has been allocated to Southern Derbyshire PCTs from 2007/08, has been identified as a priority area and there is the intention to use this to support and develop the existing Tier 2 service provided by Unity Mill.**

5.1.5	The North Derbyshire PCTs also provided detailed information on the number of appointments arranged with the North Derbyshire Community Alcohol Team in 2005/2006. This information is illustrated in Chart 1. Information is collected by month, by PCT area and whether it is a first time appointment or a follow-up appointment. However, no information is routinely collected by the PCTs in relation to the number of people attending sessions, the number of successful outcomes (or otherwise), or the gender or age clients.

Chart 1 – Number of North Derbyshire Community Alcohol Team appointments recorded by North Derbyshire Primary Care Trusts, 2005/2006



5.1.6	Similar information was not provided by South Derbyshire PCTs. However, the South Derbyshire PCTs have undertaken an alcohol needs assessment, based on the findings of the *Alcohol Needs Assessment Research Project (ANARP)*. This assessment is reproduced in Appendix 3, and raises the following issues for South Derbyshire if the national patterns apply.
	• **An estimated 101,100 people in South Derbyshire may have an alcohol use disorder.** • **86,500 people are hazardous or harmful drinkers.** • **Of these 53,000 visit their GP every year (33,500 males and 19,500 females). It is estimated that the consistent provision of GP-based brief interventions in Southern Derbyshire would lead to 6,600 hazardous or harmful drinkers reducing their intake to low risk levels.**

	• **A further 14,600 individuals in Southern Derbyshire are estimated to be alcohol dependent. If national patterns of access to treatment are applied then nearly 93% (13,700) of these may not be accessing local treatment services.** • **National studies suggest low identification rates of alcohol use disorders in primary care and poor access to treatment for those with alcohol dependency.** • **The evidence for unmet need indicates significant potential for increasing primary care input into screening, identification and referrals of individuals with alcohol use disorders.**
5.2	**Derbyshire Drug and Alcohol Action Team**
5.2.1	The Derbyshire Drug and Alcohol Action Team (DAAT) commissions drug treatment services across the County, primarily using the Pooled Treatment Budget – the National Treatment Agency's method of funding drug treatment services. Derbyshire's "alcohol alone" services are not funded from the Pooled Treatment Budget. As of December 2006, the Derbyshire County PCT is making arrangements for future alcohol treatment services to be commissioned by the DAAT. The DAAT also commissions young people's Tier 2 and 3 alcohol treatment services alongside drug treatment services.

	<u>KEY ISSUE 7 – driving recommendation 2</u> **We welcome the transfer of responsibility for commissioning alcohol treatment services in Derbyshire to the Derbyshire DAAT. We feel that the multi-agency approach will enable commissioning to be better integrated and delivered more effectively.** **We support the idea of a Pooled Treatment Budget for alcohol treatment services. We have listened to the evidence shared with us and concur with Paul Yates, National Probation Service - Derbyshire (section 8.4) and David Sharp, Derbyshire County Primary Care Trust (section 8.6) that the DAAT has the expertise and experience to manage this area of work.**

	We also welcome the comments from John Stamp, DAAT Co-ordinator, (section 8.13) that public and patient involvement will be improved if there is a move towards Pooled Treatment Budget for alcohol services.
5.2.2	The DAAT is a partnership between a number of agencies and organisations including: • Derbyshire County Council. • Derbyshire County Primary Care Trust. • The National Probation Service – Derbyshire. • Derbyshire Constabulary. • Derbyshire Youth Offending Service.
5.2.3	The DAAT has an Alcohol Joint Commissioning Group, with Derby City Drug Action Team to help shape its priorities and direction in relation to alcohol treatment services. This Group is currently led by Paul Yates, from the National Probation Service – Derbyshire.
5.2.4	The DAAT was instrumental in securing temporary funding with the agreement of the National Treatment Agency (NTA) to support the development of Tier 2 alcohol treatment services across South Derbyshire. The NTA allowed the DAAT to commission Tier 2 services through the Mental Health Trust's Substance Misuse Team at Unity Mill, Belper, for 2006/2007, as the first part of a 2-year plan to get Tier 2 services up and running, and then to provide training to GP practices to enable primary care teams to deliver Tier 2 services, in particular brief interventions. However, no funding is secure at the present time to continue the delivery of Tier 2 services in South Derbyshire from April 2007 onwards, no the development of a training programme for primary care teams to deliver, at least, Tier 2 brief interventions.
5.2.5	In recent weeks, the DAAT has finalised service specifications for the delivery of Tier 2 and Tier 3 alcohol treatment services. Service specifications have been shared with: • North Derbyshire Alcohol Advisory Service – for Tier 2 and Tier 3 interventions in North Derbyshire, including Alcohol Treatment Requirements. • Derbyshire Mental Health Services NHS Trust – for Tier 2 and Tier 3 interventions in South Derbyshire through the Substance Misuse Team based at Unity Mill, Belper. Alcohol Treatment Requirements are included.

	• Derbyshire Mental Health Services NHS Trust – for Tier 3 interventions in North Derbyshire. Reporting Schedules have also been circulated and service providers have requested to complete them, for the period July 2006 to September 2006 (2nd quarter, 2006/2007).
5.3	**Derbyshire County Council**
5.3.1	Derbyshire County Council contributes to the funding of alcohol treatment services in North Derbyshire through its Adult Social Care budget. Information received from the North Derbyshire Alcohol Advisory Service indicates that in 2005/2006 Derbyshire County Council contributed £137,000. In 2006/2007, funding rose to £140,000. Furthermore, the County Council also "spot" purchases Tier 4 residential rehabilitation placements in the Independent Sector. These placements are to provide rehabilitation for individuals after detoxification. As there are no Tier 4 residential services in Derbyshire, all such placements are out of the County. Currently, the County Council does not differentiate between Tier 4 placements for people who misuse drugs from those who misuse alcohol. Over the last 18 months, since April 2006, 24 such placements have been made at a net weekly cost for each placement of £465 per week.
5.3.2	Derbyshire County Council is represented on the DAAT Board, and so is able to influence the commissioning of alcohol treatment services.
5.3.3	Derbyshire County Council does not make a similar contribution to the commissioning of alcohol treatment services in Southern Derbyshire.
5.3.4	<u>Supporting People</u> The Supporting People Partnership has agreed to invest in additional services for young people and people with chaotic lifestyles. The services that are funded involve independent living support based on individual needs. The additional investment is approximately £500,000 in 2006/2007, with funding agreed to 2009/2010.

5.4	**Derby Hospitals NHS Foundation Trust**
5.4.1	Dr Andrew Austin is a Consultant Hepatologist at Derby City General Hospital. The Hepatology Service manages with liver disorders, including cirrhosis. In recent months the waiting list for Dr Austin's clinic list has been reduced for Derbyshire patients as a result of the setting up of the Tier 2 alcohol treatment service managed by the Unity Mill Substance Misuse team. This has meant that some patients are able to access services locally, and in a more appropriate setting. It also means that people who need access to the Tier 4 Hepatology Service are able to access it quicker. Dr Austin and his team are not able to access clinical psychology services for patients. His service can provide support to people for them to manage their alcohol use, but not psychology or psychiatric services. However, Dr Austin is aware of feedback from a patient who has accessed the psychology service through Job Centre Plus, as a consequence of an alcohol misuser seeking employment. Dr Austin believes that follow-on services, that are services which are provided to help people into education or employment, are important – partly due to relieving some boredom in people's lives, boredom which makes alcohol more attractive. One of the striking issues is the rising number of people aged 35 to 45 years dying from alcohol related diseases. Furthermore , there is a great number of women patients on the clinic list than in recent years

KEY ISSUE 8 – driving recommendation 1

Dr Andrew Austin commented that the introduction of a Tier 2 alcohol treatment service in April 2006 has had a positive effect in reducing waiting times to his outpatients Liver Clinic. This means that:

- **Patients can access appropriate Tier 2 interventions quicker and locally.**
- **Patients who need specialist Tier 4 interventions can access them from Derby City General Hospital because the waiting lists are consequently shorter.**

We also understand that hospital based treatments are more expensive to deliver than community based treatments, and so can draw the conclusions that if a Tier 2 service is not available from April 2007, then:

- **Patients requiring Tier 2 alcohol treatment interventions will be referred to the Tier 4 service at Derby City General Hospital**
- **The Hepatology Service waiting lists will be longer, and so access to services will take longer.**
- **The cost to the Primary Care Trust will be greater, if the same number of patients who currently access the new Tier 2 service then access the Tier 4 service, or fewer patients will be seen.**
- **Patients needing to access Tier 4 services (which can be life-saving) will have to wait longer to see a Consultant.**

Mary Johnson, a Clinical Nurse Specialist from the Hepatology Service, and John Stamp, Derbyshire DAAT Co-ordinator confirmed these issues at the event on 31 October 2006 (see section 8.12).

We believe that this is an *INVEST TO SAVE* issue and ask Derbyshire County PCT to explore how it can identify the reduced need for in-patient and out-patient services at Derby Hospitals NHS Foundation Trust and Chesterfield Royal Hospital NHS Foundation Trust as a result of investment in Tier 2 and Tier 3 alcohol treatment services. We feel that it will be worthwhile to produce information on the impact of the Unity Mill Tier 2 service on the Hepatology Service at Derby City General Hospital, from April 2006 onwards.

5.5	**Other sources of information which may inform commissioning**
5.5.1	Local Alcohol Profiles for England (LAPE)
	The North West Public Health Observatory and the Alcohol Research Unit at the Centre for Public Health, Liverpool John Moores University has brought together routine data and intelligence from a range of sources (including the Department of Health and the Home Office), to provide the first national indicator set intended to inform and support local, regional and national alcohol policy. The indicators will help prioritise and target local areas of concern and encourage cooperative working and partnerships to reduce the costs and harms associated with alcohol misuse.
5.5.2	Local alcohol profiles are available at district level, for:
	• Amber Valley • Bolsover • Chesterfield • Derbyshire Dales • Erewash • High Peak • North East Derbyshire • South Derbyshire.

5.5.3	The profiles rank the Derbyshire's districts against 353 other local authorities in relation to twelve alcohol related indicators, set out in Table 7. More information is available on http://www.nwph.net/alcohol/lape/

Table 7 – Local Alcohol Profiles for England (LAPE) – Alcohol related indicators

Alcohol related months of lost life – males
Alcohol related months of lost life – females
Mortality from chronic liver disease – males
Mortality from chronic liver disease – females
Alcohol related hospital admission – males
Alcohol related hospital admission - females
Alcohol specific hospital admission – males
Alcohol specific hospital admission - females
Alcohol related recorded crimes
Alcohol related violent offences
Alcohol related sexual offences
Synthetic estimate of binge drinking

5.5.4	These indicators should not be used in isolation of other information, and so a detailed analysis has not been undertaken. Comparisons between the Derbyshire districts have not been made for the same reason. However, it is noted that:
	Amber Valley • No indicators in the top quartile.
	Bolsover • Top quartile for alcohol related months of lost life - females, mortality from chronic liver disease – females, alcohol related hospital admission – males, alcohol related hospital admission – females, alcohol specific hospital admission – females.

	Chesterfield • Top quartile for alcohol related hospital admission – males, alcohol related hospital admission – females, alcohol specific hospital admission – males, alcohol specific hospital admission – females and alcohol related sexual offences.

	Derbyshire Dales • Top quartile for alcohol related months of lost life – males.
	Erewash • Top quartile for mortality from chronic liver disease – females.
	High Peak • Top quartile for alcohol related months of lost life – females, mortality from chronic liver disease – females, alcohol related hospital admission – females and alcohol specific hospital – females.
	North East Derbyshire • No indicators in the top quartile.
	South Derbyshire • Top quartile for mortality from chronic liver disease – males.
5.5.5	Community Health Profiles
5.5.6	Community health profiles are available for each district area, and aggregated at a County level. They are compiled for the Department of Health and NHS by the Association of Public Health Observatories. More information is available at www.communityhealthprofiles.info
5.5.7	Two alcohol related indicators are available, *Binge Drinking* and *Hospital Related Stays*. The Binge Drinking indicator is the same as the LAPE binge drinking indicator. The Hospital related stays indicator is similar. For Derbyshire County, the incidence of Binge Drinking is "not significantly different from the England average"; the Alcohol Related Hospital Stays is reported as "significantly better than the England average".

	<u>KEY ISSUE 9 – driving recommendation 1 and 2</u> **The absence of any real and meaningful local data on which to commission alcohol treatment services is a concern to the Member Task Group.** **However, we welcome the work undertaken by the South Derbyshire Primary Care Trusts to interpret the ANARP data on a South Derbyshire basis (section 5.1.6).** **We also welcome the comments from John Stamp, DAAT Co-ordinator and Rachael Boulton (DAAT Commissioning Manager) (section 8.13) that a Health Needs Assessment of alcohol treatment services in Derbyshire is underway. We feel that this should be completed urgently in order to inform Derbyshire's public sector 2007/2008 budget planning cycles.**
5.6	**Commissioning Young People's Alcohol Treatment Services**
5.6.1	No detailed information has been shared with the Review team about arrangements for commissioning young people's services.
	<u>KEY ISSUE 10 – driving recommendation 2</u> **The focus of the Review is the sustained, at least, delivery of Tier 2 and Tier 3 alcohol treatment services in Derbyshire. However, the Member Task Group also wanted to find out about alcohol treatment services for young people in Derbyshire.** **We were disappointed that we did not receive much information on commissioning and service delivery of services for young people, but we are grateful to BASE III and BREAKOUT for participating in the round table event on 31 October 2006. (Sections 6.6, 6.7, 8.9 and 8.11).**

5.7	**Children, Parents and Families**
5.7.1	Turning Point's[5] publication, *Bottling it up – the effects of alcohol misuse on children, parents and families* provides a children and parents perspective on alcohol use and misuse. Table 8 sets out some key statistics relating to families and alcohol misuse.

[5] Turing Point is a UK social care organisation providing services for people with complex needs, including those affected by drug and alcohol misuse.

Table 8 – The Impact of Alcohol Misuse on Families

Up to 1.3 million children in the UK are affected by parental alcohol problems.
Five times as many children could be affected by parental alcohol problems as by parental drug misuse.
Around one third (360,000) of all domestic violence incidents are linked to alcohol
Marriages are twice as likely to end in divorce where there are alcohol problems.

5.7.2	In the Turning Point research, children aged 12 to 18 were asked:
	• How their knowledge and attitudes to alcohol had been affected by their experiences?
	• What effect they thought their parents drinking had on them as an individual?
	• What effect parental drinking had on their family?
	• What helps children to cope with their situation?
	• What services could do / have done to help?
	Parents views were also sought:
	• Identifying the support they had received from services to support them and their children.
	• What impact they considered their alcohol use to have had on their children.
	• What would help in terms of services, practical support, information needs?
5.7.3	Turning Point report recommendations include:
	• ***Services across adult-based alcohol services and children's services should be reconfigured to provide a co-ordinated approach to meet the needs of the whole family.***
	• ***Specialist services outside of the family environment should be available for children affected by parental alcohol misuse. Adult services should ensure that there is specific provision to support parents. Agencies should adopt a family-focused approach and promote initiatives that bring parents and children together.***

	• ***All adult service working with alcohol misusers should be trained in supporting people to develop parenting skills.*** • ***Adult services working with alcohol misusers should ensure they have appropriate processes and skills to assess the potential impact of alcohol on their children and parenting support. Children's service should have clear protocols to support the early identification of alcohol-misusing parents and their children, outlining referral routes and care pathways for interventions from specialist services.*** • ***Specialist services should have clear child protection procedures.*** • ***Services should be vigilant and consistent in their processes to identify families where alcohol misuse is a factor.*** • ***Children need to be given a voice in expressing their needs and identifying the appropriate interventions to meet them. Measures need to be put in place to ensure that this directly influences the planning and commissioning of services.***
5.7.4	Derbyshire County Council commissioned a research project *Improving Outcomes for Children affected by Parental Drug and Alcohol Problems.* The work was started in March 2005, and there are plans to publish the finds soon.
5.7.5	The project planned to interview parents and carers, and where possible children and young people, from up to twenty five families across Derbyshire.
5.7.6	In practice, the project gathered information from eighteen families (listening to 25 parents) and eight children from five families were also interviewed.
5.7.7	It is hoped that it will deliver useful information on the experiences of children, parents and families and alcohol misuse, and inform future commissioning.
5.7.8	It is also hoped that the report isolates alcohol misuse from drug misuse and drug and alcohol misuse, to ensure that an accurate picture of alcohol misuse is given.

6.	**Delivering Alcohol Treatment Services in Derbyshire**
6.1	There are a range of organisations and agencies delivering a range of alcohol treatment services across Derbyshire. Table 9 illustrates this point.

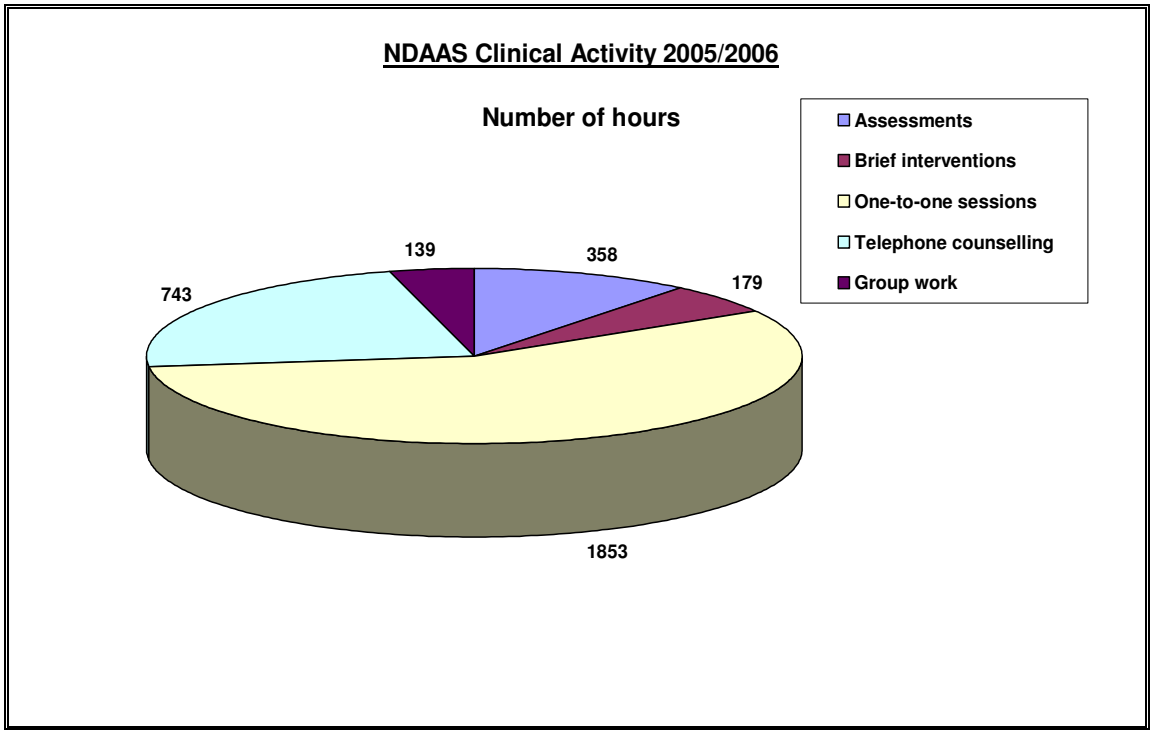
Table 9 – Main alcohol treatment service providers across Derbyshire

Tier 1	**There are a range of Tier 1 service providers, including:** • **GP surgeries** • **Health Centres** • **Derbyshire County Council, through its Older Adults Services and Children and Younger Adults Services** • **Hospitals** • **Criminal justice settings**
Tier 2	• **North Derbyshire Alcohol Advisory Service (NDAAS) – North Derbyshire (except Glossopdale)** • **Derbyshire Mental Health Services NHS Trust (through the Substance Misuse Team based at Unity Mill, Belper (South Derbyshire)**
Tier 3	• **Derbyshire Mental Health Services NHS Trust, through the North Derbyshire Community Alcohol Team (North Derbyshire) and the Substance Misuse Team based at Unity Mill, Belper (South Derbyshire)** • **North Derbyshire Alcohol Advisory Service (NDAAS) – North Derbyshire (except Glossopdale)**
Tier 4	• **Chesterfield Royal Hospital** • **Derby Hospitals NHS Foundation Trust** • **Derby Mental Health Services NHS Trust (through the Psychiatric Unit based in Derby Royal Infirmary)** • **Residential rehabilitation is delivered outside of the County**

6.2	In the context of the Review, the Project Board focussed its attention on Tier 2 and Tier 3 treatment services. The Review Member Task Group is clear in its understanding that the different organisations delivering Tier 2 and Tier 3 alcohol treatment services may delivering those services differently, and achieve positive outcomes with clients. The focus of the Review is on commissioning rather than the quality or robustness of service delivery, and so no judgements will be made on the issue "which is the best Tier 2 or Tier 3 model of care".
6.3	**North Derbyshire Alcohol Advisory Service (NDAAS)**
6.3.1	NDAAS is a team of specialist, non-medical alcohol workers offering a free counselling, advice and information service throughout North Derbyshire for people over 18 years old. NDAAS is not aligned to a NHS Trust or Derbyshire County Council – it is a voluntary organisation, registered as a charity.
6.3.2	NDAAS provides Tier 2 and Tier 3 alcohol treatment services.

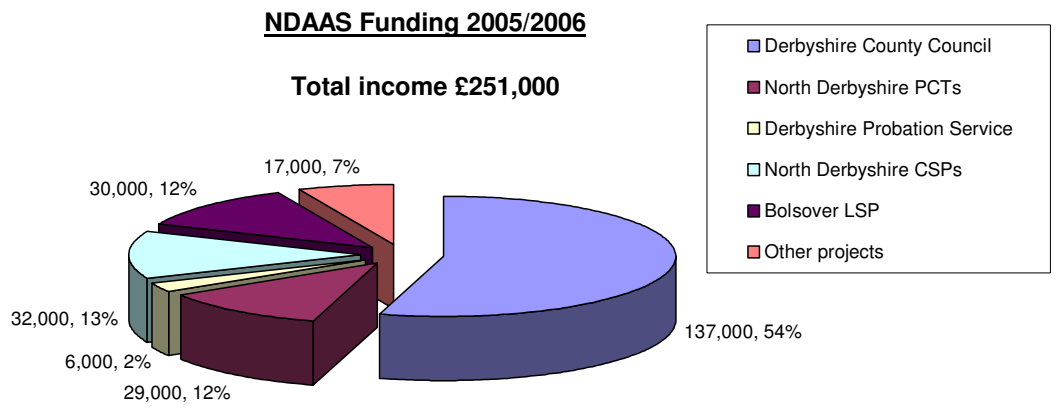
6.3.3	The Team, which comprises five full time equivalent recurrently funded posts and two full time equivalent temporary contract workers (non-recurrent funding), provides structured advice support and brief interventions to problem drinkers and their families and carers. The non-recurrently funded posts relate primarily to criminal justice work. Chart 2 illustrates the work of the Team during 2005/2006, by types of activity with clients. The chart illustrates the number of hours spent on different types of activity. The Team also provides advice and information to health and social care professionals, including specialist Primary Health Care training in screening and brief interventions. Furthermore, the Team has a close working relationship with the North Derbyshire Community Alcohol Team based at Chesterfield Royal Hospital.

Chart 2 – NDAAS Staff / Client Activity, 2005/2006



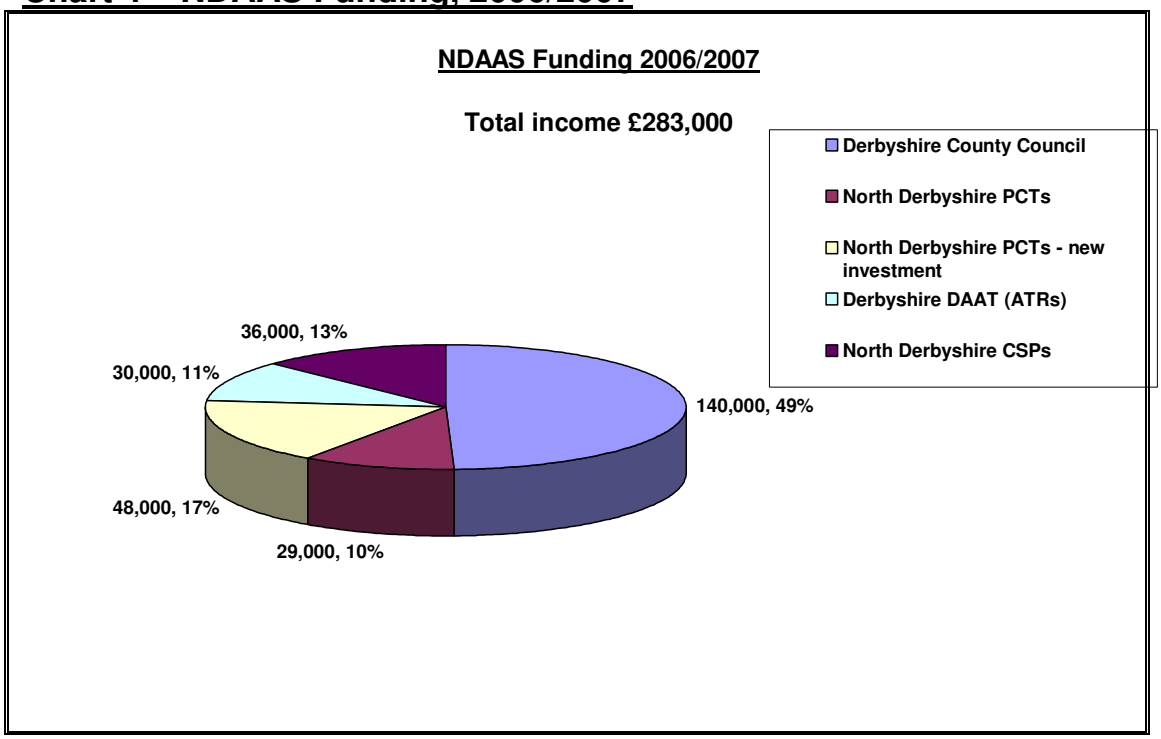
6.3.4	NDAAS staff are actively encouraged in the planning and delivery of services. Volunteers, too, play a key role. NDAAS will support service users becoming part of the Team, provided a series of tough conditions are achieved, including: • Free of problematic substance misuse for a period of two years. • Successful selection at a NDAAS volunteer selection evening. • Undertake an eight-week DANOS training course. • Pass an interview to the satisfaction of NDAAS and the British Association for Counselling and Psychotherapy. • Appropriate qualifications, preferably a Post Graduate Diploma in Counselling to be a Counsellor or a Certificate to be a Support Worker. For some, a barrier to following this route is funding. For more information on volunteering, see section 6.3.19.
6.3.5	NDAAS – Income 2005/2006 For the period 1 April 2005 to 31 March 2006, NDAAS income was £251,000. Chart 3 illustrates a breakdown of the sources of income for 2005/2006. The largest source of funding was from Derbyshire County Council through the Social Services budget, at £137,000.

Chart 3 – NDAAS Funding, 2005/2006



6.3.6	NDAAS – Income 2006/2007 For the period 1 April 2006 to 31 March 2007, NDAAS income is £283,000. Chart 4 illustrates the breakdown of sources of income for 2006/2007. Again, the largest source of funding is from is Derbyshire County Council through the Social Services budget, at £140,000. However, the Derbyshire DAAT has invested £30,000 to resource Alcohol Treatment Requirements – this is non-recurrent funding from Derbyshire Constabulary and the National Probation Service - Derbyshire, and is aimed at the delivery of ATRs. The funding from the North Derbyshire Community Safety Partnerships is £36,000 – which is also non-recurrent and ceases in March 2007. **Further enquiries have been made to Derbyshire County Primary Care Trust, since some of the financial data provided to the Health Scrutiny review is conflicting. Clarification has been sought, and at the time of preparation of the final review report further information has not been made available.**

Chart 4 – NDAAS Funding, 2006/2007



6.3.7	NDAAS Tier 2 Services NDAAS delivers information, advice and counselling to clients. Some of the clients will access Tier 2 services immediately, whilst others may "move" to Tier 2 services after a period of time receiving structured care planned counselling (a Tier 3 service).

6.3.8	<u>NDAAS Tier 3 Services</u> NDAAS also provides Tier 3 alcohol treatment services for some clients. • Clients usually receive an average of six sessions of support as part of their Care Plan, including an initial assessment[6]. However, they can access further help through a NDAAS support group or make a follow-up appointment with a trained counsellor as long as is helpful to them. Support is usually reduced after six sessions in order to allow for new clients to access the service. • Alcohol Treatment Requirements (ATRs). • Eight-week Community Safety Project programme to reduce violent and offending behaviour. • Relapse prevention through one to one and group work.
6.3.9	Clients are usually seen in various bases, including: • Chesterfield (Bayheath House, the NDAAS HQ) • Bakewell • Bolsover • Buxton • Chapel • Dronfield • Eckington • Glossop • Killamarsh • Matlock • New Mills • Shirebrook Home visits which are not usually undertaken. NDAAS believes that this approach, which demands a client getting out of their home and comfortable environment to seek assistance tests motivation. Furthermore, there are also safety and resource issues arising in relation to home visits. Home visits require two members of the Team to make the visit and there are insufficient resources to do this. If a client does not attend an appointment, then the Service will contact them by post encouraging the client to make contact again.

[6] The initial assessment is what takes place when someone refers themselves initially to the Service – this forms part of a triage assessment where details of drinking history and pattern are taken so that they can be signposted where appropriate treatment is appropriate, this is provided to every client who contacts the service. From this a comprehensive assessment is offered, where in most cases a care plan is opened. This assessment identifies all risk areas and covers full risk assessment looking at children, vulnerable adults, physical health, psychological health, crime and disorder, social and occupational issues and housing. It is from this assessment that a care plan is drawn up and the structured counselling work begins.

6.3.10	NDAAS clients are usually adults with alcohol related problems - either those dependent on alcohol or binge drinkers. It is often the case that clients perceive they have a problem with alcohol. Clients also include: • Relatives and carers. • Those chronically physically dependent on alcohol are referred to the North Derbyshire Community Alcohol Team, based at Chesterfield Royal Hospital. They are often referred back to NDAAS following detoxification and managed withdrawal. NDAAS operates two support groups – one for those clients who have stopped drinking but want to access continuing support and one for relatives or carers of problem drinkers – *"RAFT - Relatives and Friends Together"*.
6.3.11	<u>NDAAS – Activity - 1 April 2005 to 31 March 2006</u> • 1027 clients receiving treatment services from NDAAS. • 698 new referrals, an average of 58 per month. • 180 Tier 1 health and social care workers trained in alcohol awareness and brief interventions. • 472 hours of telephone work with Tier 1 health and social care workers.

Table 10 – NDAAS Source of referrals, 2005/2006

Source of referral 2005-2006	Number of clients referred
Self referral	394
Probation Service	95
GP Practice	68
North Derbyshire Community Alcohol Team	26
Community Mental Health Team	24
Not known	20
Hospitals	14
Arrest referral scheme	13
Derbyshire Social Services	11
Client's own family	10
North Derbyshire Community Drug Team	9
Prison / Police	9
Mental health services	3
Housing	2
TOTAL	698

Table 11 – NDAAS – Referrals by location, 2005/2006

NDAAS Referrals by location 2005-2006	Number of clients
Chesterfield	**328**
High Peak	**127**
Bolsover	**100**
North East Derbyshire	**60**
Derbyshire Dales	**52**
Other area	**20**
Not known	**11**
TOTAL	**698**

6.3.12	NDAAS Activity – 2006/2007 During the period April 2006 to June 2006 (the 1st quarter of the 2006/2007 year), NDAAS had 287 active clients. • 50% (144) were active in the service for at least 12 weeks • 72% (207 were active in the service for 6 weeks or more. These figures include some clients who only accessed the service once.
6.3.13	NDAAS is keen to get real and useful feedback from clients, but has found it difficult to do so. An ex-RAFT service user is an executive member of the NDAAS Management Committee. Service user involvement has been identified as an area for improvement.

6.3.14	NDAAS Alcohol Treatment Requirements NDAAS is funded by the Derbyshire DAAT to deliver alcohol treatment requirements for clients in the criminal justice system between May 2006 and March 2007. All activity is Tier 3, and clients are referred from the Courts, via the Derbyshire Probation Service. Clients are expected to undertake a 12-week one-to-one programme with reporting requirements. Attendance is mandatory, and failure to attend could result in breach and a custodial sentence. Table 12 sets out NDAAS Alcohol Treatment Requirement activity for the six-month period from May 2006 to October 2006.

Table 12 - NDAAS Alcohol Treatment Requirement activity, May 2006 to October 2006

NDAAS ATRs - Type of activity	Number of clients
New referrals	47
Assessments provided	55
Active clients	56
One to one sessions delivered	117
Video links	5
Risk strategy and three-way meetings[7]	8
Outcomes	
Completed ATRs	6
Number of cases closed – client abstinent	2
Number of cases closed – reduced drinking	2
Number of case closed – unsuccessful	2

[7] A three-way meeting is a meeting involving the Client, their Probation Officer and the Alcohol Worker.

6.3.15	<u>NDAAS – ATRs – Future Funding</u> Currently, funding for the Criminal Justice work in North Derbyshire is due to end in March 2007. This means that from April 2007, NDAAS will not be providing any alcohol treatment services to clients who have entered the service through the criminal justice system. NDAAS has shared a view that this Derbyshire DAAT decision conflicts with the high profile messages around the impact of binge drinking on individuals and communities. Initially, NDAAS estimated that £33,000 funding would be required to continue to deliver the Alcohol Treatment Requirement work in 2007/2008. However, given experience of managing court referrals and assessments, it is likely that the numbers entering the Service will be higher than originally forecast. Currently, the ATR service is staffed by 1.5 working time equivalents, which is likely to increase to 2 working time equivalents. This will result in a total cost to NDAAS of £55,000, i.e. a further £22,000. Furthermore, ATR funding should be recurrent – and NDAAS believes that it should be commissioned and performance managed by the Derbyshire DAAT.

6.3.16	<u>NDAAS – Community Safety Projects</u> Chesterfield, North East Derbyshire and Bolsover Community Safety Partnerships provide £12,000 each towards the delivery of Tier 2 and Tier 3 work with clients whose offending is linked to alcohol misuse. Clients have included prolific offenders. Clients are usually referred to NDAAS by the Derbyshire Probation Service or Derbyshire Police. Clients voluntarily attend a programme eight weekly one-to-one sessions lasting for one hour each. The programme helps people look at the factors in their life which may contribute to their drinking and related offending. The programme is suitable for anyone who drinks problematically and who becomes either verbally or physically aggressive as a result of this. The programme is also suitable for those involved in domestic violence. The process also involves the referral agent, Police or Probation, and some clients have been able to access training to support education and employment. The High Peak and Dales Community Safety Partnership also provides £5,000 funding on an ad-hoc basis for the delivery of locality based projects. Currently, 103 Community Safety Project clients are active to the service. Tables 12 and 13 illustrate some key activity statistics for Tier 2 and Tier 3 treatment services provided under the Community Safety Project.

Table 13 – NDAAS Community Safety Project – Tier 2 - Key Statistics, April 2006 to October 2006

NDAAS Community Safety Project – Tier 2 - Key activity statistics April 2006 to October 2006	Number of activities delivered
Number of Tier 2 workers trained in alcohol awareness and reducing alcohol related violent behaviour in sessions for • Young people's services • Youth offending teams • Pub Watch	127
Clearance has been achieved for a Community Safety Project worker to gain direct access to Derbyshire Police's custody suites (previously access was only available to drugs workers)	

Table 14 – NDAAS Community Safety Project – Tier 3 - Key Statistics, April 2006 to October 2006

NDAAS Community Safety Project – Tier 3 - Key activity statistics April 2006 to October 2006	Number of activities delivered
Number of referrals to NDAAS CSP project	67
Number of assessments	48
Number of one-to-one sessions provided by NDAAS	167
Number of people completing the 8-week programme	20
• Clients completed programme with either abstinence or controlled drinking	(12 of 20)
• Clients completed the course with reduced drinking	(4 of 20)
• Clients relapsed or no change	(4 of 20)

6.3.17	<u>NDAAS – Community Safety Projects – Future Funding</u> Currently, funding for the Community Safety Project is due to end in March 2007. This means that from April 2007, NDAAS will not be providing any alcohol treatment services to offenders who have voluntarily agreed to participate in a short-term programme to address their alcohol misuse. NDAAS comments that in order to continue to deliver the current profile of Tier 2 and Tier 3 treatment services work across North Derbyshire, recurrent funding of £48,000 would be required.
6.3.18	<u>NDAAS and Quality Standards</u> NDAAS works within a variety of quality and performance standards. Examples include: • Clinical services are provided in association with the British Association for Counselling and Psychotherapy. • Staff job descriptions and Individual Personal Development Plans are linked to the Drugs and Alcohol National Occupational Standards (DANOS). • The Investors in People Award in 2004. • The services are working to QuADS[8] compliance. • Use of Alcohol Concern's alcohol outcomes spider[9] • Service user feedback – anecdotal rather than structured.

[8] QuADS – Quality in Alcohol and Drugs Services Organisational Standards. Alcohol Concern and the Standing Conference on Drug Misuse (SCODA). 1999. The Standards may be used as an assessment tool, to help with the development of quality in service.

[9] Alcohol Concern's Alcohol Outcomes Spider is an outcomes tool for alcohol agencies to measure the key outcomes of their wok with alcohol service users – a summary copy is on the Alcohol Concern website - http://www.alcoholconcern.org.uk/files/20051003_102318_Outcomes%20spider%20abstract.pdf

6.3.19	<u>NDAAS – Volunteering</u> NDAAS also offers a programme of support for volunteers, including: • A comprehensive training package. • In-house clinical supervision. • Group supervision. • Non-clinical and personal development support. • Out of pocket expenses. • Support for volunteers to work towards DANOS standards. • Ongoing training. • A regular newsletter. • An opportunity to contribute skills and be involved with an innovative community service. • An opportunity to gain experience of face to face work in a specialist area. NDAAS has a selection process – references will be required and applicants must attend a volunteer training course. Only after an interview and Police checks will a volunteer be offered work with clients. There are currently two active volunteers. One of the volunteers is a counsellor and the other a support worker. Recently four other volunteering joined the NDAAS staffing roll on a sessional basis or on a temporary contract, arising from the new PCT investment. A further six volunteers are being trained, and four of these should be active by Spring 2007. NDAAS recruits from areas where there is need, i.e. in response to high numbers of referrals in the High Peak area in 2005, NDAAS recruited new volunteers from that area. Demand in 2006 has been in the Chesterfield and North Derbyshire area.

6.3.20	NDAAS – Key achievements • 50% of assessment appointments offered within 3 to 5 days of initial client contact with the Service. • All appointments offered within 10 days of initial client contact with the Service. • All clients who contact the Service receive a brief intervention. • 77% of clients engaged in care planned work in 2005/2006 achieved either abstinence or controlled or reduced drinking status at discharge.
6.3.21	Significant issues that NDAAS is currently facing are shared in Table 15. Notes of a meeting with the NDAAS Team are set out in Appendix 4. The Team considers *'What it does well'* and *'What improvements could be made'*.

Table 15 – NDAAS - Significant issues informing future service delivery

• **NDAAS feels that the Derbyshire DAAT is over managing the Alcohol Treatment Service by putting constraints on what NDAAS should and should not be doing.**
• **NDAAS has recently entered in to Service Level Agreement (SLA) with the Derbyshire DAAT. The SLA containing many pages of monitoring requirements. Adherence to these requirements means that training and qualified counsellors are having to reduce their workload, in most cases now four clients per day rather than five or six clients, in order to the increased demands of care planning and monitoring. NDAAS is concerned that there is an increased and unmet resource requirement to undertake performance management.**
• **NDAAS is sensitive to and aware of the on-going concerns over funding of alcohol treatment services, particularly around Tier 2 services in the south of the County, and the recent changes in the PCT boundaries, resulting in the Derbyshire County PCT.**
• **Funding concerns mean that staff can only be employed on short-term contracts. Experience has shown that this way of working often results in good members of staff being lost.**
• **Volunteers require on-going support, supervision and training – all of which require funding.**
• **Close proximity of services to those to support drug users can put off some potential clients.**

	<u>KEY ISSUE 11 – driving recommendation 3</u> **We are surprised that the numbers of referrals by Derbyshire County Council Social Services Department (now Older Adults Services and Children and Younger Adults Services) to the North Derbyshire Alcohol Advisory Service, the North Derbyshire Community Alcohol Team and the Substance Misuse Team at Unity Mill are so low:** • **2% of NDAAS referrals in 2005/2006 (11 out of 698 referrals -see Table 10)** • **1% of North Derbyshire Community Alcohol Team (NDCAT) referrals in January to April 2006 (2 out of 211 referrals - see Chart 5)** • **1% of Unity Mill referrals in April to July 2006 (1 out of 195 referrals - see Chart 7)** **Given the incidence of alcohol misuse reported in the ANARP report (section 3.3) and the anticipated prevalence of alcohol misuse in South Derbyshire (section 5.1.6 and Appendix 3), and also the evidence documented in the Turning Point report, *Bottling it up – the effects of alcohol misuse on children, parents and families (section 5.7.1),* and the work commissioned by Derbyshire County Council, *Improving Outcomes for Children affected by Parental Drug and Alcohol Problems,* which was stared in March 2005 we would have expected a higher number of referrals – particularly amongst parents with an alcohol misuse issue.** **We believe that Derbyshire County Council should carry out an analysis of why the referral numbers are low and provide a report on staff training in the Children and Younger Adults Services Department and the Older Adults Services Department, in relation to identifying alcohol misuse amongst clients / service users.**

	<u>KEY ISSUE 12 – driving recommendations 1 and 2</u> **We were also surprised at the higher numbers of self referrals to Tier 2 and Tier 3 alcohol treatment services across Derbyshire.** • **56% of NDAAS referrals in 2005/2006 (394 out of 698 referrals -see Table 10)** • **31% of NDCAT referrals in January to April 2006 (65 out of 211 referrals - see Chart 5)** • **37% of Unity Mill referrals in April to July 2006 (75 out of 195 referrals - see Chart 7)** **We welcomed the activity by the Chesterfield, North East Derbyshire and Bolsover Community Safety Partnerships and NDAAS, NDCAT Team and Unit 10 (a Chesterfield based youth service project) on a project to produce advice cards (section 4.5.5).** **We believe that initiatives such as this should continue and be developed across the County and that additional funding for the provision of appropriate treatment should be identified so that services are not comprised nor are waiting lists increased.**

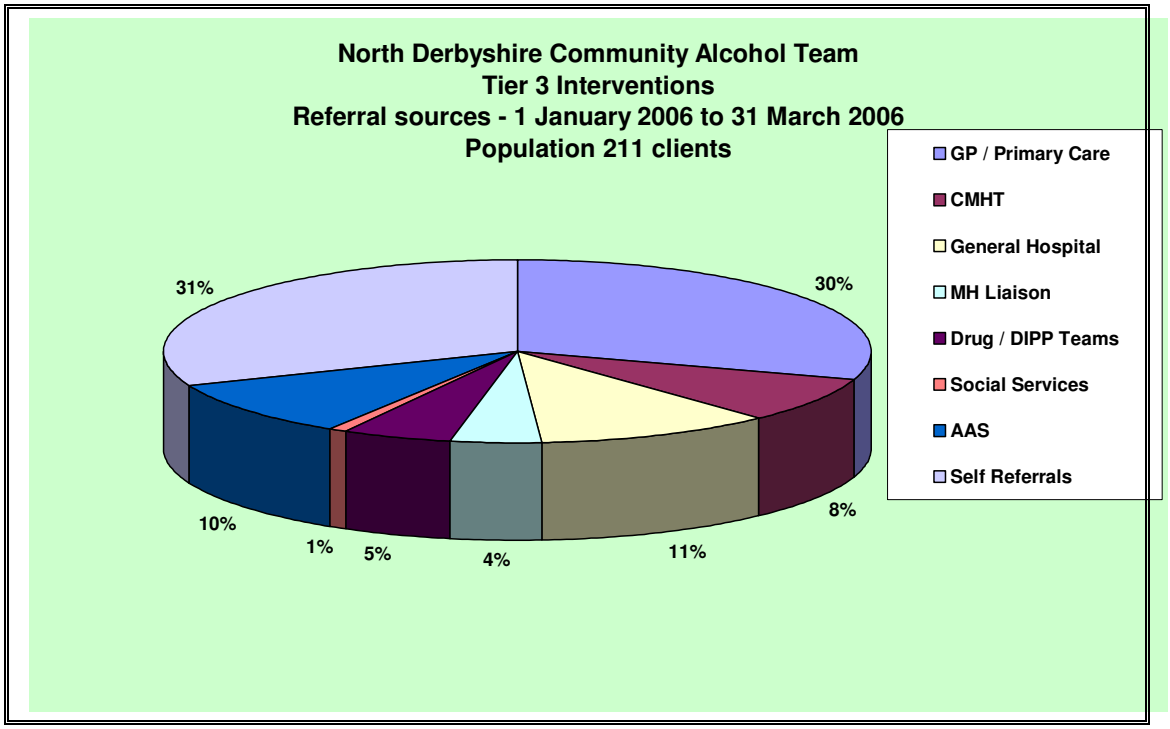
6.4	**<u>North Derbyshire Community Alcohol Team, based at Chesterfield Royal Hospital (NDCAT)</u>**
6.4.1	The North Derbyshire Community Alcohol Team is part of the Derbyshire Mental Health Services NHS Trust. It is based at Chesterfield Royal Hospital, providing Tier 3 interventions.
6.4.2	It is commissioned by the Derbyshire County Primary Care Trust as part of a block contract with Derbyshire Mental Health Services NHS Trust. The Mental Health Trust reported that the budget for 2006/2007 is £175,000.

6.4.3	From April 2005 to March 2006, the North Derbyshire Community Alcohol Team had over 800 referrals, and saw and assessed 650 people. In total, the service holds records for over 4,500 patients. 72% of service users are aged 35+. About 55% of the clients are male, with 45% female. There seems to be a faster rate of increase of referrals amongst females, and indeed females cause more physical damage to their body than males as a result of alcohol misuse. Clients include a range of people with different backgrounds, and different life experiences. The Team has strong links with the North Derbyshire Alcohol Advisory Service and consultants based at Chesterfield Royal Hospital. This means that clients can be referred into the Community Alcohol Team quickly if necessary, and also away from the Community Alcohol Team, either to NDAAS on completion of detoxification or to the in-patient consultant-led tea, if a more urgent and intensive intervention is needed. The Team does some work with employers, with patient consent, since the support of employers is vital during and after a phase of treatment. The Team is also seeing more people on methadone scripts than in previous years, as people with a drugs misuse issue find alcohol an alternative to heroin. These clients drink alcohol to feel good. About 10% of the Team's current caseload is made up from this cohort.

6.4.4	Steve Miller, the North Derbyshire Community Alcohol Team Leader comments, *"The Tier 3 alcohol alone treatment service is an open access service. This means that people do not need to be referred in to the service by a third party – but can do so themselves, perhaps by telephoning the team.* *"There is currently a waiting list to access treatment, of up to 3 weeks – this is the first time in fifteen years that there has been a waiting list. In recent months, the team has had to complete new and additional paperwork. An assessment normally takes around 40 minutes, but the additional paperwork is adding a further 40 minutes to the process. We currently have a member of staff on maternity leave and these two elements in combination has led to the current position of a 3 week waiting list.* *"The provision of further staff resources is considered necessary to bring the waiting period down and to keep it there without compromising patient care.* *Tell us about the services that are provided?* *"The team mainly meets clients through home visits, on a one to one basis. This is important, since there is a need to better understand the home environment and family situation. The care plan will be influenced by these conditions, and in particular if a partner at home is drinking, perhaps all day. If a client has a medical problem, then this is also taken into account, and may lead to a service provided at hospital, rather than at home. In certain circumstances, particularly where there is regular drinking within a household, the team will recommend an in-patient detoxification. Also, the risk assessment may identify a safety/mental health issue, which may mean that the service is delivered in the Hartington wing of the hospital.* *"The team uses a variety of approaches, preferring to use treatment services relevant to an individual's needs. This may involve detoxification using medication, but it is also about encouraging people to be in receipt of the same level of support but to gradually reduce their drinking over a 5-7 day period.* *"The team does not seek to provide a support service over a long period of time, rather being as small a part of someone's service provision as possible. Tier 3 interventions are intensive, but over a short period of time, for example 8 meetings over a period of 3 weeks."*

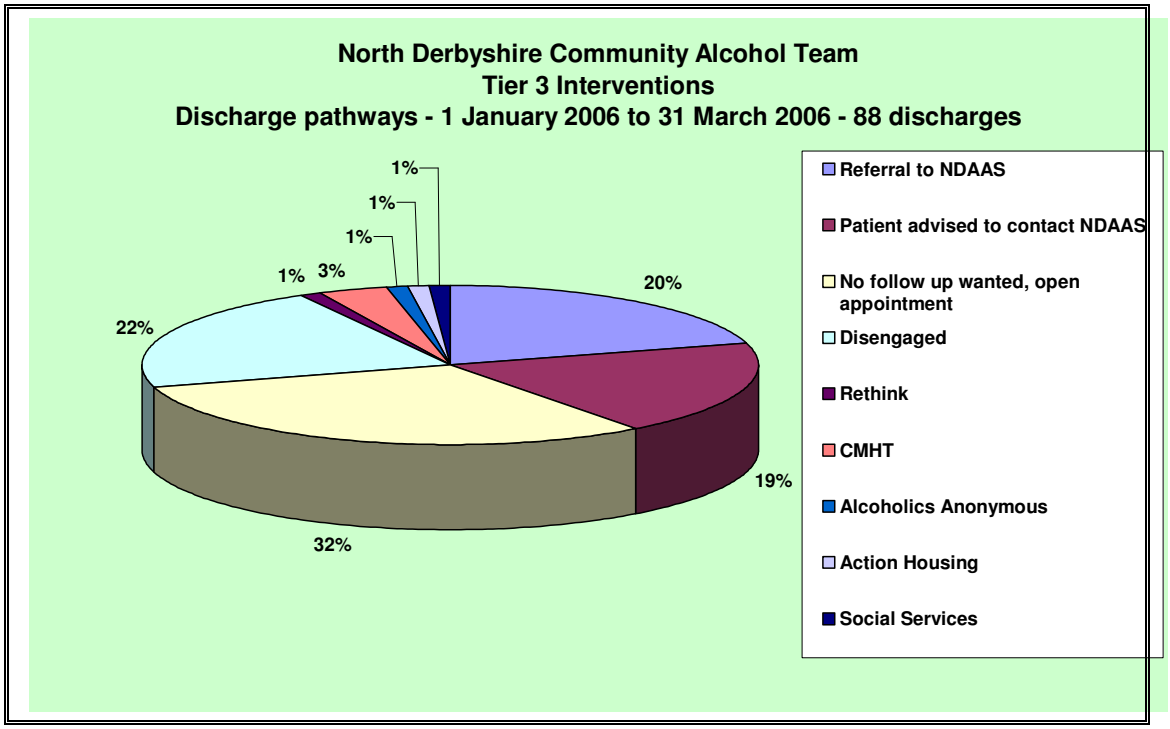
6.4.5	During 2005/2006, 54% of the treatment episodes were with clients who had previously accessed the service, and 46% of the treatment episodes were with new clients.
6.4.6	Interventions provided by the Team include: • Assessment of physical & psychological condition, home environment and suitability for community based treatment. • Work with the patient to set drinking goals. • Regaining control of drinking and reducing harmful effects • Use of motivational techniques to help the patient move towards change. • Supervised medicated home detoxification programmes • Supervised drink down programmes. • Work with family and friends offering advice on how they can move patient towards change. • Assessment for rehabilitation placements. • Commencement of medication such as Disulfiram (Antabuse – which makes a person violently ill if they ingest alcohol) or Acamprosate (Campral – which reduces craving symptoms for alcohol) and monitoring its effectiveness. • Relapse prevention.
6.4.7	Most of the Team's referrals are self referrals or are referred from primary care. Detailed information for the period January 2006 to April 2006 is illustrated in Chart 5.

Chart 5 – North Derbyshire Community Alcohol Team – Referral sources – 1 January 2006 to 31 March 2006



6.4.8	Discharge paths are illustrated in Chart 6. The North Derbyshire Community Alcohol Team either referred onwards, either directly or indirectly over a third (39%) of their clients to NDAAS. Direct referrals may be made if the Team feels that a client may not follow up the contact details shared or of the Team have specific concerns that necessitate direct contact with NDAAS. For other clients, they are given the NDAAS contact details and asked to make contact themselves.

Chart 6 – North Derbyshire Community Alcohol Team – Discharge Pathways – 1 January 2006 to 31 March 2006

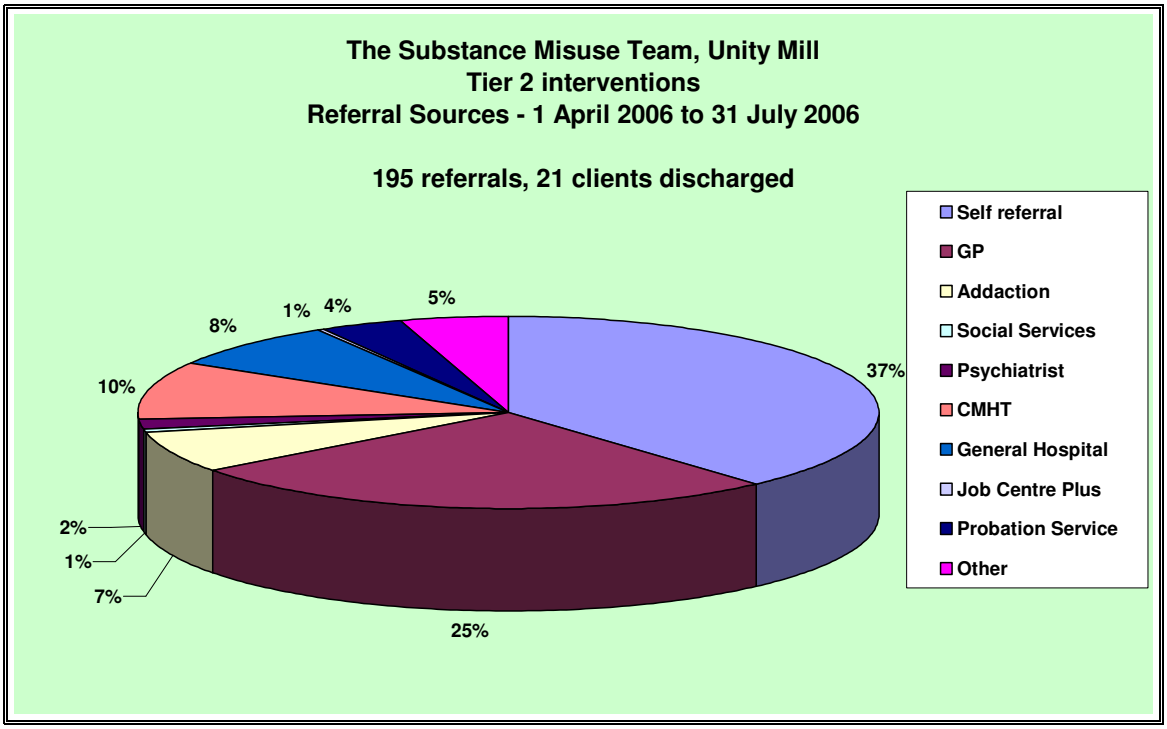


6.4.9	Further information about the North Derbyshire Community Alcohol Team may be found in Appendix 5.
	KEY ISSUE 13 – driving recommendations 1 and 2 **We are concerned that the recent introduction of performance management framework has led in the introduction of a waiting list for access to the NDCAT service (Similar comments were also made by NDAAS (Table 15, bullet point 2).** **However, we agree that the introduction of effective performance management will support better service planning and be another piece of inform to inform the commissioning and provision of Tier 2 and Tier 3 alcohol treatment services.** **We feel that the Derbyshire County Primary Care Trust (or the Derbyshire DAAT when commissioning responsibilities are transferred shortly) should provide sufficient resources service providers to undertake effective performance management and not at the expense of delivering services to local people.**

6.5	**The Substance Misuse Team, based at Unity Mill, Belper**
6.5.1	The Substance Misuse Team based at Unity Mill, Belper is also part of the Derbyshire Mental Health Services NHS Trust. It provides Tier 2 and Tier 3 interventions, including Alcohol Treatment Requirements.
6.5.2	It is commissioned by the Derbyshire County Primary Care Trust as part of a block contract with Derbyshire Mental Health Services NHS Trust. The Mental Health Trust reported that the overall 2006/2007 budget for delivering Tier 2 and Tier 3 alcohol services through the Substance Misuse Team at Unity Mill is £384,000. The current budget for the delivery of generic Tier 3 services is £244,000 – of which £30,000 has been met by the DAAT on a non-recurrent basis. The additional £30,000 is a shortfall in recurrent mainstream requirements. The source of the £30,000 was underspends in the 2005/2006 Pooled Treatment Budget – and agreed with the National Treatment Agency. However, £140,000 is non-recurrent funding through the Pooled Treatment Budget, for the provision of Tier 2 services, to increase generic Tier 3 capacity and to deliver alcohol treatment requirements across South Derbyshire during 2006/2007. Funding has not been identified by the Derbyshire County PCT (or its predecessor PCTs) for the continued delivery of Tier 2 services, the additional generic Tier 3 services or work to support ATRs in 2007/2008, or beyond. **Further enquiries have been made to Derbyshire County Primary Care Trust, since some of the financial data provided to the Health Scrutiny review is conflicting. Clarification has been sought, and at the time of preparation of the final review report further information has not been made available.**

6.5.3	Unity Mill has provided Tier 2 interventions since April 2006, across Southern Derbyshire, excluding the City area, such as: • Advice and information on harm reduction and health promotion. • Supported detoxification. • Complementary therapies. • Liaison with other agencies, and links to Tier 3 services.
6.5.4	During the period April 2006 and October 2006, it has had 318 referrals to the Tier 2 treatment service, and at October 2006 has 178 active clients, with 126 discharges.
6.5.5	Detailed information relating to client referrals is available for the period 1 April 2006 to 31 July 2006, a four month period. Chart 7 illustrates the referral source. Clients sought help with advice and information, relapse prevention and alcohol reduction plans.
6.5.6	During the period 1 April 2006 to 31 July 2006, the longest wait for an appointment was 32 days (4.4 weeks), and the shortest way was NIL days. The Team now offers an alternative appointment in Unity Mill, Belper, if there is a waiting list at one of the satellite clinics.

Chart 7 – The Substance Misuse Team, Unity Mill – Referral Sources



6.5.7	The Substance Misuse Team also provides Tier 3 interventions. These clients have more complex needs. At October 2006, there were 108 active clients.
6.5.8	Between April 2006 and October 2006, there were 38 referrals for assessment through the Alcohol Treatment Requirement system (also a Tier 3 service). At October 2006, there were 30 active clients (eight did not attend their assessment appointment).
6.5.9	The Substance Misuse team is delivering Year 1 of a 2-year alcohol treatment services strategy to build and develop a Tier 2 service across South Derbyshire. Year 1 of the strategy is aimed at getting a Tier 2 service operation, over the period April 2006 to March 2007. This is currently resourced - the source of funding is non-recurrent, i.e. time-limited to March 2007. Maggie Mousley, the Substance Misuse Team Leader comments, *"The provision of a Tier 2 service has taken some of the pressure off Tier 3 and Tier 4 services.* *"Year 2 of the strategy, for which funding has not been identified, is aimed at maintaining a service for clients, and building capacity in primary care settings, e.g. GP practices, health centres.* *"At the moment clients are offered 6 to 8 sessions, including an initial assessment. For some it will be weekly sessions, though others may prefer fortnightly sessions. At the end of these sessions we may offer a course of auricular acupuncture or refer people on to other healthcare services. Some clients may be referred to the Tier 3 service if their problems are deep-rooted and require more intervention.* *"We offer an alcohol reduction programme to our Tier 2 clients, rather than a detoxification, although we can support community detoxification if this appropriate.*

	"We also advise all our clients to develop more appropriate ways of relaxing and managing stress, such as walking, exercise, listening to music for our Tier 2 clients. For our more active clients, we encourage going to the gym. Our Tier 3 clients may have deeper issues, which will not be resolved purely by these strategies and will need more long term interventions. *"Initially, we took on Agency staff to manage the Tier 2 client list. Staff are now on fixed-term contracts, until April 2007. We need to know as soon as possible about the commissioners' future plans, in order to be able to plan ahead for our clients and our staff. We feel that this is an Invest-2-Save issue – our work at Tier 2 saves money downstream in commissioning and delivering Tier 3 and Tier 4 services.* *"We want to have more flexibility in the delivery of rural services, and intend to speak to the Commissioning Group about the differing nature of needs and services in rural areas, compared to the market towns."*
6.5.10	Further information relating to the Substance Misuse Team and alcohol treatment interventions may be found in Appendix 6.

	KEY ISSUE 14 – driving recommendations 1 and 2 **We are concerned that at this stage, December 2006, the end of the third quarter of 2006/2007, there is no decision made to deliver Year 2 of the two-year plan to develop Tier 2 alcohol treatment services in South Derbyshire. We feel that this may contribute to recruitment and retention issues amongst staff and lead to uncertainty amongst clients.** **We are also concerned that for 2006/2007 the DAAT has had to resource ATRs in South Derbyshire using Drug Pooled Treatment Budget, and that these – being Court Orders which may run from six months to three years – may be issued with no service provision available beyond 31 March 2007.** **We note that over 300 people from South Derbyshire have accessed Unity Mill Services, either the Tier 2 service or through an ATR that would not have done so without the investment from the Pooled Treatment Budget. We are concerned that some of these clients may have a service withdrawn in April 2007, and that services will not be available to other people with alcohol issues who have not yet approached the Service.** **We also note that the South Derbyshire Community Safety Partnerships have not contributed any funding towards the delivery of local campaigns to help people access alcohol treatment services, whereas the North Derbyshire Community Safety Partnerships have provided such funding to NDAAS, albeit on a non-recurrent basis (section 4.4.5).**

6.6	**BASE III – A Young People's Substance Misuse project in North Derbyshire**
6.6.1	BASE III, a Young People's Substance Misuse project is part of the Chesterfield Royal Hospital NHS Foundation Trust.
6.6.2	Details of the commissioning arrangements and funding streams have not been shared with the Review team.
6.6.3	During the period January 2006 to October 2006, BASE III had 13 referrals to the project, where the primary substance problem was identified as alcohol. Nine of the clients are female, and four are male. The average age was 16. A further 42 clients were referred where alcohol was a secondary issue. Many of the young people presenting themselves to the BASE III project aged 16 to 17 years old will have had previous involvement with the Children and Adolescent Mental Health Services (CAMHS). A large proportion, though not all, of the young people are in the local criminal justice system and known to the Youth Offending Team.
6.6.4	BASE III works with young people in their "totality" rather than individual aspects of their character. BASE III will want to develop an awareness of their employment or education situation, and to explore the triggers behind their problem drinking. BASE III offers one to one work which involves counselling, motivational interviewing and cognitive behavioural therapy.

6.6.5	Young people cite the following reasons for referral to BASE III include: • Binge drinking. • Drinking and association with anti-social behaviour. • Repeated admission to A&E departments. • Drinking to forget….. – some may relate to an earlier abusive experience. • Boredom – some have been excluded from the education system for up to two years. Dependent drinking amongst young people is not really a problem in North Derbyshire. BASE III has only worked with two young people over the last four years who have had medically supervised detoxifications. BASE III has a doctor attached to it, who will supervise detoxifications.
6.6.6	BASE III mainly works with the North Derbyshire Alcohol Advisory Service and North Derbyshire Community Alcohol Team and has strong links with Derbyshire's Children and Younger Adults Services. BASE III also works well with the Connexions Service to support entry into employment or education.
6.6.7	BASE III has ambitions to further improve its support to young people through: • More preventative and educational work with Tier 2 services. • More focused work with hard to reach groups, i.e. young people in the criminal justice system and victims of sexploitation. • Developing closer links with all agencies working with young people, including adult drug treatment teams. • Passing on a coherent harm reduction message to young people – many of whom are resistant to understanding the importance of harm reduction.
	KEY ISSUE 15 – driving recommendation 2 **We welcome the plans of BASE III to further develop alcohol treatment services to young people in North Derbyshire.** **We hope that the transfer of adult commissioning services to the DAAT will further support BASE III aims, in particular transitional arrangements for clients as their move into adulthood.**

6.7	**BREAKOUT – A Young People's Substance Misuse in South Derbyshire**
6.7.1	BREAKOUT, a Young People's Substance Misuse project is also part of the Derbyshire Mental Health Services NHS Trust.
6.7.2	It is commissioned by the Derbyshire County Primary Care Trust as part of a block contract with Derbyshire Mental Health Services NHS Trust. The Mental Health Trust reports that the budget for 2006/2007 is £146,000 – and about 40% of the workload involves young people with alcohol misuse issues.
6.7.3	At October 2006, BREAKOUT had 28 active clients, undergoing alcohol treatment interventions, where alcohol is the primary substance, and a further 32 clients where alcohol is the secondary substance. The majority of clients are aged 17/18. The number of males against females is roughly the same – though BREAKOUT reports that it is seeing an increase in the number of female clients. Bal Singh, a young person's substance misuse worker at BREAKOUT comments, "Some young people are dependent drinkers, a stage further on than binge drinking. Young people are offered a medical detoxification if they want it – but they must be psychologically ready for it to work. "More young people have accessed the service in the last twelve months compared to the previous twelve month period. "The most difficult group to work with is those young people who use cannabis and alcohol. Young people's perspective is that cannabis use is "legal" and that everyone drinks alcohol. "The Derbyshire Youth Offending Team is the biggest single referrer of young people to the BREAKOUT service. "It is important to consider the wider social needs of young people, such as employment and education, and out work must reflect this approach."

6.7.4	Of the current client list, twelve live in the Amber Valley area, eight in Erewash, and eight in the South Derbyshire Dales and South Derbyshire area.
6.7.5	The BREAKOUT team also works closely with other agencies and organisations providing services to young people, such as the Youth Offending Team, the Child and Adolescent Mental Health Service (CAMHS), Connexions, schools and the County Council's Children and Younger Adults Services Department.
6.7.6	Detailed information on transitional arrangements, helping young people access the South Derbyshire Tier 2 service delivered by the Substance Misuse Team at Unity Mill has not been shared with the Review team. However, BREAKOUT is currently working with the Substance Misuse Team to develop a joint protocol. The protocol will support the change of service provider.
6.7.7	Further information about BREAKOUT may be found in Appendix 7. It includes a reflection on *"What BREAKOUT does well?", "What BREAKOUT needs to improve on?", and other information.*
	KEY ISSUE 16 – driving recommendation 2 **We welcome the plans of BREAKOUT to further develop alcohol treatment services to young people in South Derbyshire.** **We hope that the transfer of adult commissioning services to the DAAT will further support BREAKOUT aims, in particular transitional arrangements for clients as their move into adulthood.**

7.	**Service user involvement in securing better alcohol treatment services Derbyshire**
7.1	The views of people accessing alcohol treatment services in Derbyshire were sought during the period August to September 2006. Round table interviews were arranged with the co-operation of the North Derbyshire Alcohol Advisory Service and the Derbyshire Mental Health Service NHS Trust. Additionally, the Derbyshire DAAT shared details of the Swadlincote Alcohol Self Help Group, the only independent alcohol self help group in Derbyshire.
7.2	Interviews were held in: • *Chesterfield* – seven people participated, in three separate sessions. Two people decided not to consent to the use of the information gathered at a session. • *Belper* – four people participated in a singe session. Two people decided not to consent to the use of the information gathered at the session. • *Swadlincote* – six people participated, in two separate sessions. Three people decided not to consent to the use of the information at one of the sessions, and one person at that session subsequently shared information relating to a complaint about the Substance Misuse Team based at Unity Mill. The three other participants are members of the Swadlincote Alcohol Self Help Group, all of whom agreed to contribute to the review. • *Long Eaton* – one person participated in a single session. A further session was planned for Ilkeston, but no-one attended. Comments are summarised in Table 16.
7.3	Additionally, Derbyshire Voice[10] agreed to participate in the review. One of their service user representatives shared information on how Derbyshire Mental Health Services NHS Trust listens to the view of service users as part of their public involvement process. Comments are summarised in Table 17.

[10] Derbyshire Voice – an independent company who promote and support the views and opinions of receivers of mental health services in Derbyshire

7.4	All service users who participated in the round table interviews were invited to the *Commissioning Alcohol Treatment Services* event on 31 October. Eight current or recent users of alcohol treatment services in Derbyshire attended the event, and were provided with an opportunity to ask questions of the commissioners and service providers, or the Health Scrutiny members. A Derbyshire Voice representative also attended the event.
7.5	In 2005, the Derbyshire Mental Health Services NHS Trust undertook a *Drug and Alcohol Services Client Satisfaction Survey*. The Survey, undertaken every two years, included the views of people accessing Mental Health Service drug and alcohol treatment services across Derby and Derbyshire. It did not include users of the North Derbyshire Alcohol Advisory Service, unless they were accessing the North Derbyshire Community Alcohol Team services.
7.5.1	Information is gathered for Unity Mill and North Derbyshire Community Alcohol Team service users. However, in relation to the Unity Mill service users, information is reported as an aggregate of drug, alcohol and polydrug users, and so it is not possible, from the summary report, to identify alcohol users views and perspectives[11].
7.5.2	The survey is very useful at identifying views and perspectives of the North Derbyshire Community Alcohol Team. 100 questionnaires were sent to service users, and 26 were returned. Table 18 illustrates some of the key issues raised.

[11] The questionnaire is comprehensive and it would be possible to segregate Unity Mill views by examination of the individual data.

Table 16a – Listening to service users – key issues arising from round table discussions

Swadlincote Alcohol Self Help Group

• The Group was established in September 2005. It currently has four regular members. Members have different needs around alcohol misuse.
• Members were disappointed with the change in alcohol treatment service provider, from Addaction to Unity Mill, over the Winter / Spring period 2005/2006.
• Members feel that the Addaction service was more personalised and goal oriented. Addaction also provided staff cover when a therapist was away or on-leave and controlled breathing was offered by Addaction, as another complementary therapy. Addaction also offered 12-week training courses on alcohol issues, and group sessions. Unity Mill does not provide other complementary therapies, any training courses or host group sessions.
• What does the Unity Mill service do well?   ○ Services are provided in the Swadlincote Addaction offices.

• What could be improved?
  ○ Unity Mill could have a more permanent base in Swadlincote, and further develop the range of locally delivered services, particularly training and development.
  ○ Information on alcohol treatment services being made available on the Unity Mill / Mental Health Trust website.

• Other issues
  ○ The DAAT is not supportive of alcohol alone service users in Swadlincote. The DAAT Ex-Users Forum is for drug users, and some meeting agendas do not include anything relating to alcohol.
  ○ The Swadlincote Alcohol Self Help Group is not supported financially or in any other way by the DAAT or by the Substance Misuse Team based at Unity Mill. It has been difficult finding suitable, safe and free-to-use premises to meet in.
  ○ The transition between the cessation of the Addaction service and the setting up of the Unity Mill service could have been handled better. We know that local GPs were also not informed of the changes.

Table 16b – Listening to service users – key issues arising from round table discussions

North Derbyshire Alcohol Advisory Service – service user perspectives

Five NDAAS service users shared their experiences, over two separate round table interview sessions.
• Access to NDAAS ○ NDAAS is based in Bay Health House, Chesterfield, near the town centre, and adequate pay and display car parking. Service users comment that public transport connections are good. ○ The NDAAS team is happy to work around client needs and availability, rather than the other way around. Appointments can usually be arranged within 24 hours. ○ The Reception area could be improved – the layout and the approach of staff towards visitors. ○ Some service users have concerns about the shared use of Bay Heath House with drug service users, and feel uncomfortable in the waiting area. They also feel that their personal circumstances are not similar to those of drug users.
• What does NDAAS do well? ○ The NDAAS Team have a positive and welcoming approach. Service users feel valued. ○ Service users have a named counsellor. The frequency of appointments is based upon need. ○ Service users are not seen as alcoholics, but as people with an alcohol issue. NDAAS recognise that there may be some "blips" on the way, times when a person consumes more alcohol than planned. ○ NDAAS has strong links with the Tier 3 Community Alcohol Team service at Chesterfield Royal Hospital. ○ Training opportunities exist for counselling. ○ NDASS work with families. ○ NDAAS work with employers. ○ NDAAS shares some information on the impact of alcohol on a person's body. ○ Tuesday evening group sessions are welcome.

- One participant commented ***"The help I got in working out when critical periods would occur and how to deal with them was very good. I wasn't 'spoon-fed' but challenged to come up with my own ideas and then given support from NDAAS".***

- **What could NDAAS do better?**
  - **More information could be provided on the impact of alcohol on a person's body. Service users want to find out as much information as they can about alcohol misuse.**
  - **Service users are sometimes advocates of NDAAS and it would be helpful to know how best to encourage others to contact NDAAS.**
  - **Information and support on education and learning opportunities. This could be linked to a person's need to occupy the time they may be *"otherwise drinking alcohol"*. Service users see NDAAS as a gateway to learning rather than as providers of learning services.**
  - **More emphasis to raising awareness of coping strategies and lifestyle issues.**
  - **Therapies other than acupuncture could be offered.**
  - **Access to information about NDAAS and its services should be available in public libraries.**

Table 16c – Listening to service users – key issues arising from round table discussions

The Substance Misuse Team based at Unity Mill – service user perspectives

Three Unity Mill service users shared their experiences, over two separate round table interview sessions. A further service user shared some information regarding complaints about the Unity Mill service – these issues are summarised too.

• **Access to the Substance Misuse Team's services**
  ○ **Unity Mill provides peripatetic services across several towns in South Derbyshire. The main base is at Unity Mill, Belper.**
  ○ **Service users found that the community based services were valuable, meaning less travel, though not all services are available in all locations, for example acupuncture is not provided in Long Eaton, though counselling is provided there.**
  ○ **Timings of complementary therapies (acupuncture) may not be suitable for people who work during weekdays. Evening sessions would be preferable.**

• **What does the Substance Misuse Team do well?**
  ○ **The Team is very professional. Team members have a positive and flexible approach – they are 'customer focused'. They make people feel at ease, and are empathetic and not judgemental. Team members build clients confidence and accept that there may be 'blips' on the way. Clients are treated with respect.**
  ○ **Where problems have been encountered, the Team has listened and issues resolved quickly.**
  ○ **Premises are comfortable and welcoming.**
  ○ **Service users have a named counsellor, who can be accessed easily. Appointments are based upon client needs, and may be weekly, or monthly, or over some other period.**
  ○ **Services are delivered locally, rather than being 'Belper-centric'.**
  ○ **Auricular acupuncture is available, promoting relaxation and better sleep patterns. The benefits were explained well too.**
  ○ **Unity Mill provides a 'springboard' to something else.**

- **What could the Substance Misuse Team do better?**
  - **Improve communications and information flow between Unity and Mill and service users.**
  - **Improve publicity, and advertise is places where people are, for example public libraries and supermarkets. Self-referral to the service should be promoted since some GPs don't take alcohol issues seriously.**
  - **More information could be provided on the impact of alcohol on a person's body. Service users want to find out as much information as they can about alcohol misuse.**
  - **The Substance Misuse Team provides a '9 to 5' service. This is a barrier to people who need access an alcohol treatment services, including complementary therapies.**
  - **Alternative arrangements should be made if a therapist is away, rather than cancelling the service or offering appointments some distance away from home.**
  - **The Service could improve ways of listening to service users' experiences.**
  - **The Service could arrange group sessions, or introduce a 'feedback group'. One participant commented, *"It's nice to know the Service is working for someone else too".***

- **Complaint about the Substance Misuse Team**
  - **Details remain confidential – though the main issue arises from a cancelled appointment (by the Unity Mill Team) and subsequent poor communication between the Substance Misuse Team and the service user.**

Table 17 – Listening to Derbyshire Voice

• The Derbyshire Voice service user representative on the Derbyshire Mental Health Services NHS Trust Substance Misuse (Alcohol and Drugs) Best Practice Group enjoys participating in the meetings, particularly working with people interested in improving services.
• The Derbyshire Voice representative is not involved in the development of the Agenda for these meetings.
• The Derbyshire Voice representative on the Best Practice Group may provide information to the Group on plans to further develop services from a personal perspective. He does not have the resources to make detailed or representative contributions.
• The Derbyshire Voice representative is not invited to training sessions relating to new initiatives or service developments that other members of the Best Practice Group has access to.
• What works well?   ○ Being part of a team interested in improving substance misuse services.

• What could be improved?
  ○ Links between the Best Practice Group and the strategic direction of the Trust.
  ○ Developing links between the Best Practice Group service user representative and service users.
  ○ Agenda planning arrangements, involving service users.
  ○ Participation in Best Practice Group meeting by senior managers.
  ○ Best Practice Group findings and outcomes, at times, appear to be compromised by costs and professional views.
  ○ The Best Practice Group should also look elsewhere for evidence of good practice, rather than starting from scratch.
  ○ Improved recompense for participating in the Best Practice Group – all other members are salaried Trust staff.

Table 18

Summary of key issues arising from a Derbyshire Mental Health Services NHS Trust survey of North Derbyshire Community Alcohol Team services (NDCAT), 2005 (26 responses)

Gender
62% male, 31% female, 7% not identified

Age
Two service users under 35 years, twenty-one over 35 years, three not identified age

Ease of access to service
92% found it easy to access the NDCAT service

Waiting time
58% seen within 10 days, 35% seen between 10 days and one month.

Change of alcohol use?
81% had changed their alcohol use since going to NDCAT

Help wanted
The three main areas of need were:

- **Talking through problems with a worker**
- **Admission to hospital / detox unit**
- **Help with mental health problems**

Did the client get the help they wanted?
65% got the help they had sought, 23% did not get the help they sought

What other services could be available?
Most respondents wanted support with *relapse prevention*.

Did the client feel involved in their treatment?
69% reported that they did feel involved in their treatment.

Were clients involved in writing their care plan?
39% of clients were involved in writing their care plan, whilst 35% were not involved. The Mental Health Trusts comments that these figures may reflect that there are a limited number of treatment options available at NDCAT, which would mean that the number 'not involved' would be higher than usual.

KEY ISSUE 17 – driving recommendation 4

We would welcome more emphasis given to patient involvement in shaping improvements in alcohol treatment services.

We are pleased that Derbyshire Mental Health Services NHS Trust undertakes a survey of service users every two years. Information yielded from the survey gives a good indication of service users and their needs. However, the final report does not isolate service users with alcohol issues, from service users with drugs issues, or drugs and alcohol issues.

This issue was raised in the round table interviews, and by the Swadlincote Alcohol Self Help Group and by Derbyshire Voice.

It was also an issue raised at the round table event on 31 October by Commissioners, Service Providers and by service users. In particular, John Stamp, the DAAT Co-ordinator, indicated that if a Pooled Treatment Budget for alcohol services is established, then service user involvement activity will be introduced. Paul Yates, The National Probation Service – Derbyshire, and Chair of the Alcohol Commissioning Group also agreed that the service user involvement would be beneficial.

The NDAAS Team also identified patient involvement as an area for improvement.

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Service users also identified opportunities for alcohol treatment services providers to signpost, in some way, service users towards learning, development and employment opportunities. Interventions may be around lifestyle issues, or personal development, such as assertiveness or confidence building.

At the round table event on 31 October, Rachel Boulton, DAAT Commissioning Manager, commented that it is important to help people into employment and education, including people coming out of prison, and that this is an area for further development.

Mary Johnson, Hepatology Team at Derby City Hospital, and Steve Miller, North Derbyshire Community Alcohol Team and Maggie Mousley, Substance Misuse Team all concurred with the benefits of supporting service users into education and employment.

We don't feel that these services should be provided directly by Tier 2 and Tier 3 service providers, but rather that networks with appropriate providers are established and maintained.

KEY ISSUE 19

We would like to thank Derbyshire Mental Health Service NHS Trust and the North Derbyshire Alcohol Advisory Service for providing us with the opportunity to listen to service users views.

We recognise that a limited number of people participated in the round table sessions, and some did not feel able enough to confirm their comments. Where confirmation of the interview notes was not received from service users, then those comments were not included in the Review findings.

We feel that this is a start, and should be continued – a view shared by service users.

The detailed information provided to the Review by service users will remain confidential, and names of participants will not be shared with others.

We would also like to thank the North Derbyshire Alcohol Advisory Service for enabling us to listen to the views of the NDAAS Team. These views are shared in Appendix 4, and we are pleased to see that there is congruence between the NDAAS Team and NDAAS service users.

8.	**Commissioning Alcohol Treatment Services in Derbyshire – Issues arising from the Round Table debate on 31 October 2006**
8.1	Over 35 people attended the debate, with representation from: • Derbyshire County Primary Care Trust (Alcohol treatment service commissioners) • Derbyshire Mental Health Services NHS Trust (delivering Tier 2 interventions in South Derbyshire and Tier 3 interventions across Derbyshire. Alcohol Treatment Requirements are also supported in South Derbyshire. The Trust also delivers a South Derbyshire young person's substance misuse project, BREAKOUT.) • North Derbyshire Alcohol Advisory Service (Tier 2 service providers in North Derbyshire and also delivering Alcohol Treatment Requirements (a Tier 3 intervention) • Derby Hospitals NHS Foundation Trust (providing inpatient and outpatient hepatology[12] for (generally) South Derbyshire residents • Chesterfield Royal Hospital NHS Foundation Trust (providing • The National Probation Service • The Drug and Alcohol Action Team (DAAT) • Derbyshire County Council – councillors and officers • Derbyshire Voice • Eight current or recent users of alcohol treatment services in Derbyshire The group included members of the Derbyshire Drug and Alcohol Team Board.
8.2	The event was led by Councillor Roger Wilkinson, Chair of the Member Task Group overseeing the Review, supported by Councillors Sharon Blank, Frank Hood and Peter Riggott. David Lowe, the Chair of Derbyshire DAAT, and an Assistant Chief Executive of Derbyshire County Council set the context for the meeting, followed by presentations by: • Commissioners and providers of resources. • Service providers.

[12] Hepatology – treatment of liver disorders

	Health scrutiny councillors and service users were able to ask questions of each speaker at the end of his or her presentation, and at the end of each session and at the end of the meeting.
8.3	**David Lowe, Chair Derbyshire DAAT Board and Assistant Chief Executive, Derbyshire County Council** • DAAT funding is focused on drugs. • For 2006/2007alone, the National Treatment Agency has agreed that the DAAT can spend 2005/2006 Pooled Treatment Budget money (normally used for drug related treatment) on delivering Tier 2 alcohol treatment services in South Derbyshire. • Currently, no source of funding to support the delivery of Tier 2 interventions in South Derbyshire from April 2007 has been identified by the Primary Care Trust. • The delivery of alcohol treatment services is a high and rising priority – and funding should follow high priority services.
8.4	**Paul Yates, Assistant Chief Officer, the National Probation Service – Derbyshire, and Chair of the DAAT Alcohol Joint Commissioning Group** Principles • It is important that the DAAT establish a Pooled Treatment Budget for Alcohol, particularly given the success of the Drug Pooled Treatment Budget. • The DAAT does not have a performance management role for alcohol treatment services – this is problematic. • Alcohol is a priority issue for communities, more so than drugs. A large proportion of people with an alcohol problem are assaulting people. • We should be aiming to introduce a needs based service, based on the needs of service users. The National Probation Service • The Probation service supervises offenders. We do not provide healthcare. However we work with NDAAS and Unity Mill teams too, on helping offenders to access Tier 2 services and with Alcohol Treatment Orders. Feedback from offenders with Alcohol Treatment Requirements is positive about the services delivered by the NDAAS and Unity Mill teams.

	• Offenders are predominantly binge drinkers, but people do cross over between binge drinking and dependent drinking. • We know that alcohol treatment has better success than drug treatment. • We also know that violent crime is linked to alcohol misuse. One of the Probation Service priorities is addressing domestic violence, which is also linked to alcohol. • Sex offenders say that alcohol is a disinhibitor to committing crime. • Our main concern is that there aren't enough Tier 2 and Tier 3 interventions available across Derbyshire to meet demand, so the likelihood of reoffending increases. Peak pressures are experienced at Christmas time too. • In summary, alcohol is the biggest single problem in Derbyshire in relation to offending, and it remains an issue for the Probation Service that access to healthcare services is problematic. If need is not met, then there will be more disruption to Derbyshire communities.
8.5	**David Sharp, Director of Commissioning, Derbyshire County Primary Care Trust** • We are driven by *Choosing Health, the Alcohol Harm Reduction Strategy for England* and Health Needs Assessments. • There is a new Derbyshire County PCT, and commissioning Tier 2 and Tier 3 alcohol treatment services is an issue for us. • We see the Health Scrutiny review as an opportunity for us, rather than a problem. We know that we need to harness active GP involvement in Tier 2 interventions. • We feel that this is an Invest-to-Save issue – where money invested in preventative services will save money downstream, for example in A&E admissions. The new Payments by Results system should also have a positive impact in preventing ill health. • We don't make a distinction between binge drinkers and dependent drinkers, but are aware that different alcohol misusers have different needs. • The Pooled Treatment Budget works well for drugs services and we would want to explore if similar can be introduced for alcohol.

8.6	**Rachael Boulton, Commissioning Manager, Derbyshire Drug and Alcohol Treatment Team** • We have set up an Alcohol Joint Commissioning Group, led by Paul Yates. • In November 2006, we are introducing a performance management framework relating to alcohol treatment. We have not done this before. • One of our priorities is to undertake a mapping exercise. We will involve service users in this exercise. • We don't want service users to develop a dependency on treatment services. We believe that there is more to the medical model of alcohol treatment, and that it is important to help people into employment and education, including people coming out of prison. Generally, in Derbyshire we're not very good at it, but where we do provide support there is evidence that it works. This is an area for development.
8.7	**John Stamp, DAAT Co-ordinator** • Young people's substance misuse services are commissioned and delivered differently to adults services. • The DAAT is funded by the Young People's Partnership Grant for the provision of substance misuse services, including for drugs and alcohol. • In North Derbyshire, the young people's substance misuse service, BASE III, is delivered by the Child and Adolescent Mental Health team (CAMHS), which is part of Chesterfield Royal Hospital NHS Foundation Trust. • In South Derbyshire BREAKOUT, the young people's substance misuse service, is delivered by Derbyshire Mental Health Services NHS Trust. • These are Tier 3-type interventions involving care planning, and are supported by other agencies such as Connexions, the Youth Offending Team and the Derbyshire Youth Service which will provide Tier 2-type interventions such as brief interventions. • There is the potential for the Healthier Communities Improvement and Scrutiny Committee to further explore Tier 1-type services for young people, such as education preventions and the work delivered by the Healthy Schools team. • The DAAT is currently working on a substance misuse Needs Assessment.

8.8	**James Matthews, Head of Policy, Derbyshire Adult Social Care Services and DAAT Board Member** • Derbyshire County Council doesn't commission or deliver any substance misuse services. These are managed through the DAAT, though drugs and alcohol are not differentiated. • Derbyshire County Council funds residential rehabilitation for adults with a substance misuse problem (a Tier 4 treatment service). At any one time there may be up to eight people accessing this service. • Derbyshire County Council funds NDAAS to deliver Tier 2 alcohol treatment services. • Derbyshire County Council also funds housing for people with chaotic lifestyles. • The Children and Younger Adults Department has commissioned a piece of research exploring the impact of alcohol on families. This is due to report shortly. • Derbyshire County Council funds a Young Carers service.

8.9	**Ifti Majid, Director, Derbyshire Mental Health Services NHS Trust**
	
	• The Trust delivers a small South of County and interim Tier 2 alcohol treatment service, based at Unity Mill, Belper.
	• We also provide Tier 3 services across the County.
	• And a young person's substance misuse service in South Derbyshire, BREAKOUT.
	• Funding
	  ○ Tier 2 £140,000 (non-recurrent)
	  ○ Tier 3 North £175,000
	  ○ Tier 3 South £244,000.
	  ○ BREAKOUT £146,000 (about 40% of workload is alcohol related).
	  ○ Drug investment in the Trust is around £2 million per annum.
	• Presentations were made relating the Substance Misuse Team at Unity Mill, the North Derbyshire Community Alcohol Team at Chesterfield Royal Hospital and the young person's substance misuse service, BREAKOUT. These are detailed in section 6.

8.10	**Elaine Handley, Team Leader, North Derbyshire Alcohol Advisory Service** • North Derbyshire Alcohol Advice Service (NDAAS) is a voluntary organisation with charitable status, delivering Tier 2 and Tier 3 alcohol treatment interventions across North Derbyshire. • Performance management should be proportional to the investment into and the size of an organisation. NDAAS considers itself to be a small organisation, and is wary of the imposition of detailed performance management frameworks. • It is also difficult to plan effectively, when long term funding is not committed to a service. • The NDAAS team is in contact with alcohol service users every day, and we would be able to inform service commissioners of client needs. • A presentation was made relating to NDAAS. Details are in section 6.
8.11	**Matt Gould, Team Leader, BASE III – a North Derbyshire young person's substance misuse project** • The BASE III approach is look at a young person in totality, to find out more about employment, employability and education. We also listen to young people about their triggers for drinking. • Matt explained that many of his service users and potential service users are "hard to reach". This group is typically aged 16 to 17 years, may have left a young person's social care setting, and be homeless, and no longer in contact with statutory health or social care, or education services. • Matt delivered a presentation; details are set out in section 6.
8.12	**Mary Johnson, Hepatology Team, Derby Hospitals NHS Foundation Trust** • Mary is a Clinical Nurse Specialist, working with Dr Andy Austin, the Consultant Hepatologist at Derby City General Hospital. Hepatology is the study of liver disorders. • The Liver Clinic has about 25 outpatients every week – some from Derby, and some from Derbyshire. Many patients have severe liver damage due to alcohol.

	• The Liver Clinic team delivers community based services, such as home detoxification, rather than hospital based detoxification. • We will signpost patients to whatever services are available to help people with alcohol misuse. • Since the Unity Mill Tier 2 service was started in April 2006, clinic attendance has dropped with people using the Unity Mill service alternatively. This means that waiting times for access to a clinic appointment are shorter, and more importantly that those patients who need access to a Consultant Hepatologist can do so quicker. Previously, some clinic time was taken up by people who did not need to see a Consultant, and where a local Tier 2 intervention would be more appropriate. • Mary's comments were supported by **John Stamp, DAAT Co-ordinator** who reflected local experience is that this is correct, and that the Tier 4 services delivered in a hospital setting are more expensive to deliver. However, if there are no Tier 2 services from April 2007, the Hospital will see an increase in its patient list, and increased waiting times as it recommences the delivery of Tier 2-type services (at Tier 4 costs, i.e. more expensive). • Mary further explained that there was a 9-week waiting time for an appointment with Dr Austin, though many patients did not need the highly specialised support offered by Dr Austin and his team. Since April 2006, if a County-based patient is referred to Dr Austin, the Nursing Team will explore the possibility of referring the patient to the Unity Mill Tier 2 service. • Mary stressed that many of the patients she had seen would benefit from access to follow-on services such as support to accessing employment and education etc.
8.13	**Issues raised by councillors and service users** **QUESTION: Tell use about service user involvement in commissioning services?** **David Sharp, Derbyshire County PCT** – We commission the alcohol treatment services the providers offer. **John Stamp, DAAT** - The DAAT has service user involvement groups for drug treatment clients, but not for alcohol treatment clients. If there is movement towards a Pooled Treatment Budget, then it is something that would be done.

	Currently, the DAAT don't commission alcohol treatment services. **Paul Yates, The National Probation Service – Derbyshire** – We have seen how well involving service users has worked with the drugs services, and should be doing the same in future with alcohol service users. **James Matthews, Derbyshire County Council** – the research work referred to earlier, around alcohol misuse and families has involved listening to parents and children. **QUESTION: What sources of data do you use to inform commissioning?** **Helen Severns, Derbyshire County PCT** – The DAAT is working on a Needs Assessment relevant to Derbyshire. However, the only other information on alcohol misuse is at an East Midlands regional level, and Super Output Areas[13]. **QUESTION: How much money is spent on delivering alcohol treatment services in Derbyshire? What is coming in and what is going out?** **David Sharp, Derbyshire County PCT** – less than £1 million is invested in Tier 2 and Tier 3 adult treatment services (note – the service providers indicate that it is in the region of £500,000-600,000 per annum). The PCT budget is £900 million. **John Stamp** - £900,000 on delivering young people's substance misuse services. It is not broken down into drug and alcohol separately. We are just about to start a review of how much Tier 2 and Tier 3 services cost.

[13] Super Output Areas (SOAs) are small areas specifically introduced to improve the reporting and comparison of local statistics. Within England and Wales there is a Lower Layer (minimum population 1000) and a Middle Layer (minimum population 5000). Unlike electoral wards, these SOA layers are of consistent size across the country and are not subjected to regular boundary change. Source: National Statistics. More information on http://neighbourhood.statistics.gov.uk

James Matthews - £850,000 is spent on providing residential rehabilitation for drug and alcohol service users.

Paul Yates – The Probation Service does not fund healthcare issues, but probation workers work closely with alcohol teams, and provide support to offenders to ensure they can access healthcare services.

Rachael Boulton – We don't know exactly how much is spent, and what we do – this is the purpose of mapping all of the alcohol treatment activity, and that is what we are now doing.

QUESTION: Where can improvements to alcohol services be made?

John Stamp, DAAT – We need to know where we are now, and our Needs Assessment will help that. We also need to develop a performance management for alcohol treatment services and better understand costs and expenses. We need to further involve service users. We would commission services in the future on the basis of this information.

David Sharp, Derbyshire County PCT – We need to identify and work with confident services providers, who deliver services that people want.
James Matthews, Derbyshire County Council – DAAT commissioning arrangements need to be more integrated, involving alcohol treatment services.

Paul Yates, National Probation Service – Derbyshire – Feedback is that the current provision is good, and we don't want to fall back from this position on 1 April 2007. It is important that the Probation Service works with and further develops the two current service providers.

QUESTION: If there are no Tier 2 alcohol treatment interventions planned in South Derbyshire from April 2007, where will patients go?

John Stamp, DAAT – There is no easy answer to that question. The DAAT will do its best between now and April to work towards sustaining a Tier 2 service in South Derbyshire.

Paul Yates, National Probation Service – Derbyshire – Looking at what happens in the City, where there are no Tier 2 alcohol intervention services, we know that:

	• Offenders will offend more. • Liver clinics in Hospitals will have longer waiting lists.

APPENDIX 1

MODELS OF CARE FOR ALCOHOL MISUSE
TIERS OF INTERVENTION

Tier 1 interventions: alcohol-related information and advice, screening, simple brief interventions and referral

Definition
Tier 1 interventions include provision of: identification of hazardous, harmful and dependent drinkers, information on sensible drinking, simple brief interventions to reduce alcohol-related harm, and referral of those with alcohol dependence or harm for more intensive interventions.

Interventions
Commissioners need to ensure that a range of generic services provide as a minimum the following Tier 1 alcohol interventions:
• Alcohol advice and information.
• Targeted screening and assessment for those drinking in excess of DH guidelines on sensible drinking and for those who may need alcohol treatment.
• Provision of simple brief interventions for hazardous and harmful drinkers.
• Referral of those requiring more than simple brief interventions for specialised alcohol treatment.
• Partnership or 'shared care' with specialised alcohol treatment services, e.g. to provide specific alcohol treatment interventions within the context of their generic services.

Settings
Tier 1 interventions can be delivered by a very wide range of agencies and in a range of settings, the main focus of which is not alcohol treatment. For example: primary healthcare services, acute hospitals, e.g. A&E departments, psychiatric services, social services departments, homelessness services, antenatal clinics, general hospital wards, police settings, e.g. custody cells, probation services, the prison service, education and vocational services, and occupational health services. Such interventions can also be provided in highly specialist non-alcohol specific residential or inpatient services, which have service users with high levels of alcohol-related morbidity who may require care plans and support to facilitate their access to alcohol-specific provision. Examples include: specialist liver disease units, specialist psychiatric wards, forensic units, residential provision for the homeless, and domestic abuse services.

Competency
This is provision that depends on at least minimal skills in alcohol misuse identification, assessment and interventions. Those delivering Tier 1 provision may require some competencies from the Drugs and Alcohol National Occupational Standards (DANOS).

Tier 2 interventions: open access, non-care-planned, alcohol-specific interventions
Definition Tier 2 interventions include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support, extended brief interventions to help alcohol misusers reduce alcohol-related harm, and assessment and referral of those with more serious alcohol-related problems for care-planned treatment. **Interventions** Tier 2 interventions include open access facilities and outreach targeting alcohol misusers, which provide: • Alcohol-specific information, advice and support. • Extended brief interventions and brief treatment to reduce alcohol-related harm. • Alcohol-specific assessment and referral of those requiring more structured alcohol treatment. • Partnership or 'shared care' with staff from Tier 3 and Tier 4 provision, or joint care of individuals attending other services providing Tier 1 interventions. • Mutual aid groups, e.g. Alcoholics Anonymous. • Triage assessment, which may be provided as part of locally agreed arrangements. **Settings** Tier 2 provision may be delivered by the following agencies, if they have the necessary competence, and in the following settings: specialist alcohol services, primary healthcare services, acute hospitals, e.g. A&E and liver units, psychiatric services, social services, domestic abuse agencies, homelessness Services, antenatal clinics, probation services, the prison service, and occupational health services. **Competency** Tier 2 interventions require competent alcohol workers who should have basic competences in line with DANOS, including those required for Tier 1. Competency can also depend on what cluster of services is provided. Front-line staff would normally have competence in motivational approaches and brief interventions.

Tier 3 interventions: community-based, structured, care-planned alcohol treatment
Definition Tier 3 interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.

Tier 3 interventions include:
• Comprehensive substance misuse assessment.
• Care planning and review for all those in structured treatment, often with regular keyworking sessions as standard practice.
• Community care assessment and case management of alcohol misusers.
• A range of evidence-based prescribing interventions, in the context of a package of care, including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse.
• A range of structured evidence-based psychosocial therapies and support within a care plan to address alcohol misuse and to address co-existing conditions, such as depression and anxiety, when appropriate.
• Structured day programmes and care-planned day care (e.g. interventions targeting specific groups).
• Liaison services, e.g. for acute medical and psychiatric health services (such as pregnancy, mental health or hepatitis services) and social care services (such as child care and housing services and other generic services as appropriate).

Settings
Tier 3 interventions are normally delivered in specialised alcohol treatment services with their own premises in the community (or sometimes on hospital sites). Other delivery may be by outreach (peripatetic work in generic services or other agencies, or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions.
Some of the Tier 3 work is based in primary care settings (shared care schemes and GP-led prescribing services), but alcohol specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care.
The work in community settings can be delivered by statutory, voluntary or independent services providing care-planned, structured alcohol treatment.

Competency
Tier 3 services require competent drug and alcohol specialised practitioners who should have competences in line with DANOS. The range of competences required will depend on job specifications and remits.
Medical staff (usually addiction psychiatrists and GPs) will require different levels of competence, depending on their role in alcohol treatment systems and the needs of the service user, with each local system requiring a range of doctor competences (from specialist to generalist) in line with joint guidance from the Royal Colleges of General Practitioners and Psychiatrists, *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers*, summarised in the National Treatment Agency for Substance Misuse briefing document *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers*.

Tier 4 interventions: alcohol specialist inpatient treatment and residential rehabilitation

Definition

Tier 4 interventions include provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.

Tier 4 interventions include:

• Comprehensive substance misuse assessment, including complex cases when appropriate.
• Care planning and review for all inpatient and residential structured treatment.
• A range of evidence-based prescribing interventions, in the context of a package of care, including medically assisted alcohol withdrawal (detoxification) in inpatient or residential care and prescribing interventions to reduce risk of relapse.
• A range of structured evidence-based psychosocial therapies and support to address alcohol misuse.
• Provision of information, advice and training and 'shared care' to others delivering Tier 1 and Tier 2 and support for Tier 3 services as appropriate.

Settings

Specialised statutory, independent or voluntary sector inpatient facilities for medically assisted alcohol withdrawal (detoxification), stabilisation and assessment of complex cases.
Residential rehabilitation units for alcohol misuse.
Dedicated specialised inpatient alcohol units are ideal for inpatient alcohol assessment, medically assisted alcohol withdrawal (detoxification) and stabilisation. Inpatient provision in the context of general psychiatric wards may only be ideal for some patients with co-morbid severe mental illness, but many such patients might benefit from a dedicated addiction specialist inpatient unit.
Those with complex alcohol and other needs requiring inpatient interventions may require hospitalisation for their other needs (e.g. pregnancy, liver problems) and this may be best provided for in the context of those hospital services (with specialised alcohol liaison support).

Competency

Inpatient and residential interventions providing medically assisted alcohol withdrawal (detoxification) and specialist assessment and stabilisation would normally require medical staff with specialist competence in substance misuse (rather than generalist GPs). The level of specialised medical staff competence required will depend on the types of service provided and the severity of the service users' problems.
Addiction specialist competences will be needed for inpatient units for severe and complex problems. Suitably competent GPs can provide support to some units for patients with less complex needs. Staff in residential rehabilitation units that are registered care homes will need to meet relevant social care national occupational standards. Hospital-based services will also be required to meet practitioner standards for independent or NHS hospitals.

APPENDIX 2

MEMBERS OF THE TASK GROUP, DRAWN FROM THE HEALTHIER COMMUNITIES IMPROVEMENT AND SCRUTINY COMMITTEE

Councillor Roger Wilkinson, Chair of the Task Group

Councillor Sharon Blank

Councillor Frank Hood

Councillor Peter Riggott

APPENDIX 3

SOUTH DERBYSHIRE ALCOHOL NEEDS ASSESSMENT, NOVEMBER 2005

1. Introduction

This paper summarises the main health effects of alcohol misuse, the evidence of need and service utilisation for alcohol misuse services in Southern Derbyshire and the evidence for the effectiveness of screening and brief interventions in settings such as primary care.

2. Health impact of alcohol misuse

In the past few years there has been a significant increase in alcohol-related death rates in England and Wales (see table 1). Heavy drinking is associated with 10% deaths from hypertension and 3.5% cancer deaths.[3]

Table 1. Alcohol related death rates with 95% confidence limits for England and Wales 2001-2003 pooled

Year	Rate per 100,000 population	Lower confidence limit	Upper confidence limit	Number of deaths
2001	10.7	10.4	10.9	5,970
2002	10.6	10.4	10.9	6,033
2003	11.6	11.3	11.9	6,580

Source: Office for National Statistics 2005

Table 2. Alcohol related death rates with 95% confidence limits for Local Authority areas in Southern Derbyshire 2001-2003 pooled

Local Authority area	Rate per 100,000 population	Lower confidence limit	Upper confidence limit
Derby	13.1	10.6	16.2
Amber Valley	5.6	3.7	8.4
Derbyshire Dales	8.4	5.5	12.9
Erewash	10.1	7.3	14.1
South Derbyshire	12.2	8.6	17.1

Other health effects include:

- A tenth of children born to alcohol-dependent mothers suffer from foetal alcohol effects.[3]
- After drinking alcohol one in seven 16-24 year olds have had unsafe sex.[3]
- Alcohol misuse is associated with psychiatric morbidity including clinical depression. Up to a quarter of suicides and nearly two-thirds of suicide attempts are related to alcohol dependency.[3]
- Between a fifth and a third of accidents are associated with alcohol misuse

Improving and expanding alcohol screening, interventions and treatment will therefore help achieve the following key targets:

- Reduce premature mortality rates from heart disease, stroke and related diseases by 40% by 2010
- Reduce premature death rates from cancer by 20% by 2010
- Reduce death rates from suicide and undetermined injury by 20% by 2010

- Reduce infant mortality rate
- Reduce under-18 conception rate by 50% by 2010
- Achieve a maximum A&E waiting time of four hours
- Improve the quality of life and independence of vulnerable older people
- Improve life chances of people with mental health problems
- Reduce crime by 15% by 2007-08
- Reduce the number of people killed or seriously injured in road accidents by 40% by 2010

3. Evidence of need and service utilisation

3.1 Prevalence of alcohol use disorders

The World Health Organisation gives three categories for alcohol use disorders:

- Hazardous drinking: drinking above sensible levels but not yet experiencing harm
- Harmful drinking: drinking above sensible levels and experiencing harm
- Alcohol dependence: drinking above sensible levels, experiencing harm and symptoms of dependence

Different categories of drinker will have different needs.

Table 3 gives estimated prevalence of alcohol use disorders for Southern Derbyshire based on national estimates from the Alcohol Needs Assessment Research Project (ANARP).[1]

Table 3. Prevalence of alcohol use disorders

	England prevalence (% of population aged 16-64)			Estimated Southern Derbyshire prevalence* (number aged 16-64)		
	Male	Female	Total	Male	Female	Total
Hazardous/ harmful alcohol use	32%	15%	23%	59000	27500	86500
Alcohol dependence	6%	2%	3.6%	11000	3600	14600
Any alcohol use disorder	38%	16%	26%	70000	31100	101100

Sources: Alcohol Needs Assessment Research Project (ANARP), Derwent Shared Services Health Informatics *based on Census population estimates for 2003

Of all the regions, the East Midlands had the lowest percentage of people with alcohol dependence at 1.6%. This compared with the highest regional percentage of people with alcohol dependence of 5.2%. However, the East Midlands had the fourth highest percentage of hazardous/harmful alcohol use at approximately 24%. The highest and lowest regional rates of hazardous/harmful alcohol use were 29% and 18% respectively.

An estimated 21% men and 9% women are binge drinkers.

3.2 **Formal identification, treatment and referral of alcohol use disorders in primary care**

The ANARP study found very low levels of formal identification, treatment and referral of patients with alcohol use disorders by GPs:[1]

- Identification rates for hazardous/harmful drinkers: 1 in 67 male and 1 in 82 female
- Identification rates for alcohol dependence: 1 in 28 males and 1 in 20 females

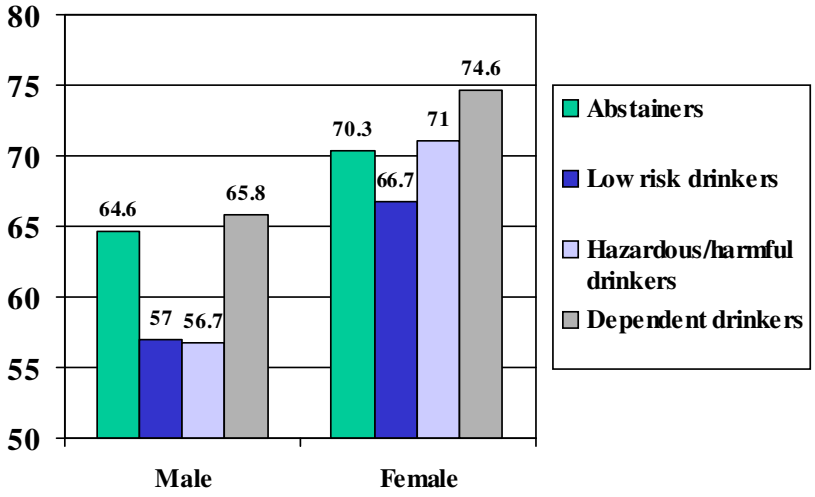
GP identification rates of younger people with alcohol use disorders were lower than for older people. Identification rates also varied by region, with GPs in the best performing regions being three to four times more likely to identify alcohol use disorders than other regions.

3.3 GP Consultations

A survey of 424 GPs in England found that in the previous month (28 days) GPs reported seeing an average of 8.1 patients with alcohol dependence, and an average of 14.2 patients with hazardous/harmful alcohol use.[1] Other estimates suggest that each GP sees 364 heavy drinkers a year.[2]

A high proportion of dependent drinkers and the majority of hazardous/harmful drinkers consult their GP annually, not necessarily with alcohol dependence as the main presenting problem (see figure 1).[1]

Figure 1. Percent of individuals in different categories reporting at least one GP consultation per annum (Psychiatric Morbidity Survey).[1]



If these patterns applied to Southern Derbyshire, this would equate to nearly 53,000 hazardous /harmful drinkers (33,500 males and 19,500 females), and 9,900 dependent drinkers (7,200 males and 2,700 females) visiting their GP every year.

3.4 Referrals

The ANARP study reported that of the alcohol use disorder patients identified by GPs, 71% were felt to need specialist treatment.[1] However the research suggested that many patients were not referred because of perceived difficulties in access (e.g. waiting times) or patient preference not to engage in specialist treatment.

The ratio of referrals to access was 2.7:1 (i.e. there were more than twice as many referrals made as accessed treatment).

The largest proportion of referrals to specialist treatment are self-referrals (36%) followed by GP referrals (24%).[1]

3.5 Accessing Treatment

An estimated 5.6% of the 'in-need' alcohol dependent population access treatment each year.[1] This equates to a Prevalence Service Utilisation Ratio (PSUR) of 18. If this figure applied to Southern Derbyshire, then approximately 13,800 alcohol dependent patients a year are not accessing treatment.

The ANARP study reported significant regional variation in PSUR rate.[1] The lowest rate was 1 in 120 (or 1%) in the North East and the highest rate was 1 in 12 (8%) in the North West. The East Midlands rate was slightly above the average for England at approximately 1 in 17 (5.9%).

Women were nearly twice as likely to access treatment than men (PSUR women 12, men 21)

At present there is no consensus on the optimal level of access for England. In North America an access level of 1 in 10 is deemed 'low', 1 in 7.5 'medium' and 1 in 5 'high'.[1]

3.6 Impact on health services

Alcohol misuse has a major impact on health services with up to 35% A&E attendances related to alcohol misuse. National estimates suggest that around one in 16 hospital admissions are related to alcohol.[5] Alcohol related diseases account for 1 in 8 bed days and 1 in 80 day cases. One study found that up to 8% of acute admissions to a care of the elderly department were of patients identified as alcohol misusers.[3]

4. Evidence for clinical and cost effectiveness

4.1 Identification and treatment

A successful alcohol treatment programme requires:[2]

- The identification and referral of people with alcohol problems
- Treatment according to individual need and motivation, including support to families where appropriate
- Services that are effective in helping vulnerable and at-risk groups

Key interventions are:[3]

- Screening and brief interventions for harmful and hazardous drinkers. A brief intervention can range form 5-10 minutes of information and advice given to an excessive drinker to 2-3 sessions of motivational interviewing or counselling.[5]
- Treatment for dependent drinkers.

National studies have found that problems with existing services may include the failure to identify and treat people with alcohol use disorders. This can impact on an individual's health, family and work. Alcohol misuse can also lead to crime, disorder and anti-social behaviour. Consequently there are significant costs to the economy, to society and the health service.[2]

Studies have also found low levels of awareness about alcohol issues among health service staff and little available information on need. The structure of alcohol treatment services varies widely, with no clear standards or pathways for treatment.

4.2 Evidence for effectiveness – screening and brief Interventions

There is good quality evidence that appropriate screening and brief interventions helps the detection and management of alcohol problems:[2,4]

- Drinkers may reduce their consumption by up to 20% following a brief intervention.[3]
- Heavy drinkers who receive an intervention are twice as likely to reduce their consumption as heavy drinkers who receive no intervention.[3]
- Brief interventions following an A&E visit resulted in fewer repeat A&E attendances compared with a control group.[3]
- When GPs and nurses are adequately trained and supported, screening and brief intervention activity increase.[3]
- For every eight hazardous or harmful drinkers receiving a brief intervention, one person will reduce their drinking to low risk levels. This can be compared 1 in 20 people for smoking cessation and 1 in 10 if NRT is included.[3]

Based on the numbers needed to treat, and the annual numbers attending their GP (see figure 1), the consistent provision of GP-based brief interventions in Southern Derbyshire could result in 4,200 men and 2,400 women each year reducing their drinking to low risk levels.

4.3 Cost-effectiveness of treatment and brief interventions

Treatment

Evidence from the 2005 UK Alcohol Treatment Trial (UKATT) suggests that for every £1 spent on treatment, £5 is saved in long term costs to the health sector.[3] It has been estimated that the provision of alcohol treatment can reduce long-term health care costs by £820-£1,600 per person (2002/03 prices).[3]

Brief interventions

The cost effectiveness of brief interventions for alcohol misuse is around £1,300 per year of ill-health or premature death avoided.[3] This is very similar to the cost effectiveness of smoking cessation interventions. One study found that brief interventions to hazardous or harmful drinkers cost only £20 (1993 prices).[3]

5. Summary

- Nationally 32% of men and 15% women are hazardous or harmful drinkers with a further 6% men and 2% women being alcohol dependent.[1]
- This equates to an estimated 101,100 people in Southern Derbyshire with an alcohol use disorder.
- Alcohol misuse has a major impact on health services with up to 35% A&E attendances and one in 16 hospital admissions related to alcohol misuse.
- Identifying and treating alcohol misuse early could lead to reduced alcohol-related health problems, reduced treatment costs and fewer admissions and consultations.[2]
- Primary-care based screening and brief interventions for alcohol misuse are clinically- and cost-effective in reducing levels of drinking in hazardous or harmful drinkers.[3]
- In Southern Derbyshire an estimated 86,500 people are hazardous or harmful drinkers. Of these 53,000 visit their GP every year and so could benefit from screening and brief interventions. It is estimated that the consistent provision

of GP-based brief interventions in Southern Derbyshire would lead each year to 6,600 hazardous / harmful drinkers reducing their intake to low risk levels.

- A further 14,600 individuals in Southern Derbyshire are estimated to be alcohol dependent. If national patterns of access to treatment are applicable to Southern Derbyshire then nearly 93% (13,700) of these may not be accessing local treatment services.
- National studies suggest low identification rates of alcohol use disorders in primary care and poor access to treatment for those with alcohol dependency.
- The evidence for unmet need indicates significant potential for increasing primary care input into screening, identification and referral of individuals with alcohol use disorders.

6. Recommendations

- Screening and brief interventions should be offered to hazardous and harmful drinkers who attend primary care and other NHS settings such as A&E departments, STD clinics or fracture clinics.
- Screening and brief interventions could also be offered in non-NHS settings such as social services and prisons
- GPs and other primary care staff should be given appropriate training and support to provide screening and brief interventions.

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Alison Pritchard
Deputy Director of Public Health November 2005

APPENDIX 4

NORTH DERBYSHIRE ALCOHOL ADVISORY SERVICE

MEETING WITH THE TEAM – 18 OCTOBER 2006

North Derbyshire Alcohol Advisory Service (NDAAS) provides Tier 2 and Tier 3 alcohol treatment services across North Derbyshire.

The Team, which comprises five working time equivalent recurrently funded posts and two full time equivalent temporary contract workers, provides structured advice support and brief interventions to problem drinkers and their families and carers.

What NDAAS does well

- Our service prevents people being admitted to hospital or accessing more intensive NHS services.
- We see people near to where they live.
- We see people quickly, within 3 and 5 days, after first contact with NDAAS – this is important to us and to the client.
- We provide cover in rural areas – this may be in a GP practice.
- We are client-centred, we understand the process of change well. We work with a client at the stage that they are at, and to clients' expectations.
- We support our clients into accessing education and employment opportunities.
- We care about our clients and each other. We are non-judgemental.
- GPs and clients like our service. If they didn't they wouldn't come back?
- We are a women-friendly service.
- We provide to support families and carers of alcohol misusers, through our RAFT support group.
- We have a flexible approach to working with clients. If they want to bring a relative to a counselling session, that is OK with us.
- We recruit, train and support volunteers.
- As a Charitable organisation, we can evolve to suit changing circumstances, compared to the NHS – another example of flexibility.
- We believe that there is always room for improvement.

What NDAAS could improve on

- We need to get better at listening to our clients, in terms of improving our services (rather than working with them professionally).
- We have to carry out more recording of what we do. At times it feels like box ticking, since we are doing this instead of seeing a client.

Things we do which we would like to do differently, but are out of our direct control to enable change

- Our premises – Bayheath House in Chesterfield – put some people off from coming to see us. It is because the premises are shared with the North Derbyshire Community Drug Team, and our some of our clients have concerns over sharing the same waiting area with drug misusers. We are happy to see these people in GP surgeries instead.
- Appointments for people in rural areas have to have the travelling time factored in. This means that for the same period of counsellor time, we would see fewer people in a rural location than a town.
- We have to do more paperwork than ever before.
- There should be access to day care services for our clients.

APPENDIX 5

NORTH DERBYSHIRE COMMUNITY ALCOHOL TEAM (NDCAT)

MEETINGS WITH STEVE MILLER, DERBYSHIRE MENTAL HEALTH TRUST – 3 AUGUST AND 11 AUGUST 2006

The meeting on 3 August was between Steve Miller and Shaun Gordon (Derbyshire County Council). On 11 August, Councillors Sharon Blank and Frank Hood met with Steve Miller, Shaun Gordon was also present.

Tell us about the North Derbyshire Community Alcohol Team?

The North Derbyshire Alcohol Treatment Service started in 1991. The current service has evolved over a period of 15 years, and has been patient led. It considers itself to be an accessible and responsive service. It is a service commissioned by the North Derbyshire Primary Care Trusts[14].

The ethos of the North Derbyshire Tier 3 service is "soft on the outside, firm on the inside, giving people the opportunity to succeed". Relationships between team members and clients are important, and this is worked on from the start as a partnership approach. Whilst clients are supported, they are in no way coerced to participate in any of the services activities. However, clients are reminded that they have to address their own problems and help themselves too and, "we empower them to do so".

It currently provides Tier 3 treatment services across all of the North Derbyshire, including the High Peak area, but excluding Glossopdale. It is part of the Derbyshire Mental Health Services NHS Trust. The service is based in the Hartington wing of the Chesterfield Royal Hospital. The role of a Tier 3 service is to get people with an alcohol misuse issue into a more stable state. Once this has been achieved, the Service will refer a person on to a Tier 2 service, i.e. North Derbyshire Alcohol Advisory Service (NDAAS).

The service does not advertise its existence publicly (other than with GPs and NDAAS). If it did, then it would be overwhelmed with requests for support. However, screening for alcohol misuse is being introduced locally in primary care settings and in the Hospital's Accident and Emergency Department and medical wards.

How many staff work for the team?

A Clinical Nurse Specialist leads the team, which includes 3 other clinicians, and one part-time administrator. Two of the team members are Non Medical Prescribers – with the other 2 due to commence over the next year. Patients will then be seen, diagnosed, treated and discharged without having to see their GP or a consultant.

[14] From 1 October 2006, it will be commissioned by the Derbyshire County Primary Care Trust

Tell us about access to Tier 3 services?

The Tier 3 alcohol alone treatment service is an open access service. This means that people do not need to be referred in to the service by a third party – but can do so themselves, perhaps by telephoning the team.

There is currently a waiting list to access treatment, of up to 3 weeks – this is the first time in fifteen years that there has been a waiting list. In recent months, the team has had to complete new and additional paperwork. An assessment normally takes around 40 minutes, but the additional paperwork is adding a further 40 minutes to the process. We currently have a member of staff on maternity leave and these two elements in combination have led to the current position of a 3 week waiting list.

The provision of further staff resources is considered necessary to bring the waiting period down and to keep it there without compromising patient care.

Tell us about the services that are provided?

The team mainly meets clients through home visits, on a one to one basis. This is important, since there is a need to better understand the home environment and family situation. The care plan will be influenced by these conditions, and in particular if a partner at home is drinking, perhaps all day. If a client has a medical problem, then this is also taken into account, and may lead to a service provided at hospital, rather than at home. In certain circumstances, particularly where there is regular drinking within a household, the team will recommend an in-patient detoxification. Also, the risk assessment may identify a safety/mental health issue, which may mean that the service is delivered in the Hartington wing of the hospital.

The team uses a variety of approaches, preferring to use treatment services relevant to an individual's needs. This may involve detoxification using medication, but it is also about encouraging people to be in receipt of the same level of support but to gradually reduce their drinking over a 5-7 day period.

The team does not seek to provide a support service over a long period of time, rather being as small a part of someone's service provision as possible. Tier 3 interventions are intensive, but over a short period of time, for example 8 meetings over a period of 3 weeks.

Tell us about your clients?

In 2005, the service had over 800 referrals, and saw and assessed 650 people. In total, the service holds records for over 4,500 patients.

The age profile of service users is 35+. About 55% of the clients are male, with 45% female. There seems to be a faster rate of increase of referrals amongst females, and indeed females cause more physical damage to their body than males as a result of alcohol misuse.

There is a range of people with different backgrounds, and different life experiences.

We do some work with employers, with patient consent, since the support of employers is vital during and after a phase of treatment.

We are seeing more people on methadone scripts than in previous years, as people with a drugs misuse issue find alcohol an alternative to heroin. People drink alcohol to feel good. About 10% of our current caseloads are made up from this group of people.

What happens when you get a referral?

In a very small minority of cases, three people in the past 12 months, a person may be referred directly into the Hartington Unit (the mental health team). In relation to each referral the team will:

- Undertake an assessment of the issues.
- Carry out a risk assessment.
- Prepare a care plan, with a client. A care plan may involve:
    - Preparation and maintenance of a drink diary – it is not an abstinence based service.
    - Arrangement of blood tests to be carried out at a local GP surgery.
    - Frequency of meetings.
- Complete an outcome measures form – usually on a subsequent visit, and "tested" on discharge to the Tier 2 service, to gauge its' appropriateness.

Tell us about your links to the NDAAS service based in Chesterfield?

The service actively encourages clients to the NDAAS Tier 2 service, delivered at Bay Heath House, Chesterfield. Clients are encouraged to refer themselves, however, some people don't do so. Often this is because they feel so much better for not drinking that they consider that they don't need further input. Of course some don't and are fine on their own but others will relapse again in the future. Indeed, if clients have a relapse they are advised to contact the Tier 3 team directly, rather than go through their GP. Communication between services is good and an appreciation of each others roles is paramount.

Tell us about your links to Chesterfield Royal Hospital?

The Tier 3 team receives referrals from the Chesterfield Royal Hospital medical consultants, Drs Keith Dear and Michael Ashton and their teams, and also refers some clients to the medical team. This means that we can refer people directly to the Consultants' team for further assessment if an in-patient detoxification is the best way forward.

Additionally, if someone comes in to the hospital to see us, we can ask them to have a blood test, and have the results within two hours.

Tell us about your links to other services?

We refer some people to long term in-patient rehabilitation centres, away from the North Derbyshire locality. It could be that they remain an in-patient for up to 12 months. In our experience, these clients do not usually return to the Derbyshire area, but set up home elsewhere.

APPENDIX 6

UNITY MILL SUBSTANCE MISUSE TEAM

MEETING WITH MAGGIE MOUSLEY, SUBSTANCE MISUSE TEAM MANAGER – 2 AUGUST AND 25 AUGUST 2006

Maggie Mousley met with Shaun Gordon on 2 August 2006, and again with Councillors Peter Riggott and Frank Hood, and Shaun on 25 August 2006.

Tell us about the Unity Mill alcohol treatment services?

The Substance Misuse Team based at Unity Mill, Belper is part of the Derbyshire Mental Health Services NHS Trust. The Team principally deliver Tier 3 structured intervention services for drugs and alcohol misusers. However, some funding is provided for the delivery of alcohol alone services.

Tier 3 drug and alcohol alone services address physical as well as emotional needs, and access to them may be a gateway to the provision of Tier 4 services such as residential rehabilitation or in-patient detoxification.

Since April 2006, the Team has provided Tier 3 treatment services for offenders in the Criminal Justice system, who as part of their sentence have an Alcohol Treatment Requirement (ATR).

Also starting in April 2006, the Team provides Tier 2 services for people who have alcohol alone issues, i.e. not a dependency on drugs, nor any other form of mental health issue.

The Team considers that *"people use alcohol to alleviate stress – our role is to help them understand their issues".*

Tell us more about how you cover South Derbyshire?

Our main "base" is the Unity Mill site in Belper. However, we deliver satellite Tier 2 and Tier 3 services in Ilkeston, Long Eaton Alfreton, Ripley Ashbourne and Swadlincote too. Sometimes we have to pay for room hire.

Where are you most busy, at the moment?

In Long Eaton we run two full-day clinics (Tier 3), two Tier 2 sessions and two auricular acupuncture sessions – 6 in total, and it is in Long Eaton where we have our longest wait for access to our services.

Tell us more about the new Tier 2 service?

"The purpose of a Tier 2 service is to help people understand why they drink more than is good for them. We offer safer drinking advice and harm minimisation information. We don't always tell people that they should stop drinking, though that could be suitable or necessary for some clients."

The Substance Misuse team provides brief intervention treatment services, such as advice and / or counselling on harm reduction, detoxification, and auricular acupuncture.

The Tier 2 alcohol alone services are provided on an "open access" basis for people registered with a GP in the South Derbyshire area, who has an alcohol issue. This means that people can self refer into the service, perhaps by calling in or telephoning Unity Mill, or they may be referred by a local GP. In fact, anyone can refer a person to the Tier 2 service.

In April 2006, the Unity Mill team carried out a mail drop aimed at GP surgeries and health centres, and also made the Derby Hospitals Tier 4 service aware of our new role.

Tell us more about the plans to deliver Tier 2 services across South Derbyshire?

The Substance Misuse team is delivering Year 1 of a 2-year alcohol treatment services strategy to build and develop a Tier 2 service across South Derbyshire. Year 1 of the strategy is aimed at getting a Tier 2 service operation, over the period April 2006 to March 2007. This is currently resourced - the source of funding is non-recurrent, i.e. time-limited to March 2007.

The provision of a Tier 2 service has taken some of the pressure off Tier 3 and Tier 4 services.

Year 2 of the strategy, for which funding has not yet been identified, is aimed at maintaining a service for clients, and building capacity in primary care settings, e.g. GP practices, health centres.

At the moment clients are offered 6 to 8 sessions, including an initial assessment. For some it will be weekly sessions, though others may prefer fortnightly sessions. At the end of these sessions we may offer a course of auricular acupuncture or refer people on to other healthcare services. Some clients may be referred to the Tier 3 service if their problems are deep-rooted and require more intervention

We offer an alcohol reduction programme to our Tier 2 clients, rather than a detoxification, although we can support community detoxification if this is appropriate

We also advise all our clients to develop more appropriate ways of relaxing and managing stress such as walking, exercise, listening to music, for our Tier 2 for the more active, going to the gym. Our Tier 3 clients may have deeper issues, which will not be resolved purely by these strategies and will need more long term interventions

Initially, we took on Agency staff to manage the Tier 2 client list. Staff are now on fixed-term contracts, until April 2007. We need to know as soon as possible about the commissioners' future plans, in order to be able to plan ahead for our clients and our staff. We feel that this is an Invest-2-Save issue – our work at Tier 2 saves money downstream in commissioning and delivering Tier 3 and Tier 4 services.

We want to have more flexibility in the delivery of rural services, and intend to speak to the Commissioning Group about the differing nature of needs and services in rural areas, compared to the market towns.

How many Tier 2 referrals have you had since April 2006?

During the period 1 April 2006 to 31 July 2006, the service had 195 new referrals into the new Tier 2 service. Most are seen within a three week period, only a few people waiting longer. Table 1 provides more information.

Also, during the period 1 April to 31 July 2006, 21 clients had been engaged and subsequently discharged.

Table 1

Source of referral	**Number referred between 1 April 2006 and 31 July 2006**
Self referral	75
GP	51
Community Mental Health Team	19
Derby City General Hospital	15
Addaction	14
Derbyshire Probation Service	13
Derbyshire Adult Social Care Services	1
	188

What is the current waiting time for access to the Tier 2 service?

Since April 2006, the shortest recorded wait for accessing a service has been 0 weeks, and the longest 4 weeks.

We aim for a maximum waiting time of 2 weeks. It may rise to four weeks at times because of the nature of the peripatetic service that we provide. We operate satellite clinics across South Derbyshire in places where our clients live, and where rooms are available. We would always seek to offer the soonest appointment locally to a client. We may be able to see a client sooner in Unity Mill in Belper, but this may not be suitable for the client.

How do you manage DNAs (do not attends)?

We record all DNAs. We also listen to the client to find out why they did not attend, and explore transport issues with them (if appropriate). We always give a client another appointment initially, but if a client chooses not to engage with our service we will discharge them unless there are areas of concern that need to be addressed. We usually allow two DNAs. Clients can be referred back in at any time

The referrer is notified of the discharge too, though the option of returning in the future if offered.

Tell us more about Tier 3 services and detoxification?

Tier 3 services are more intense than Tier 2 services. Clients' issues are more complex, and they many have physical problems associated with their alcohol use e.g. liver damage, heart problems, a mild stroke, memory loss and/or mental health issues. Often alcohol is a secondary issue to other underlying problems.

We currently have nearly 90 Tier 3 clients. Clients have a named key worker, and we will provide support over a six month period. About 60% of our clients go through the Tier 3 service, and we don't see them again.

There is a risk of Tier 3 clients forming a dependency on the service. Care plans are reviewed to ensure that we are managing specific needs, and we have a clinical psychologist on our Substance Misuse Team which helps us. We may also refer a client on to other Mental Health Services, if necessary.

Pregnant women are also prioritised in Tier 3 services, due to the impact of alcohol on an unborn child. The Unity Mill Team links in well with the midwifery service, and one of the Team has a specialism in working with mums-to-be. Currently, there are 25 pregnant women accessing Unity Mill services (for drug and / or alcohol misuse).

Detoxification is part of the Tier 3 service provision. If a client has the "shakes and sweats" it is the body reacting to a demand for alcohol. Medication can help the body cope with this demand, e.g. Librium, vitamin supplements, Antabuse.

We also see clients in the Criminal Justice System, with Alcohol Treatment Requirements – a 6-month order supervised by the Derbyshire Probation Service.

Tell us about access to Tier 4 services?

The Substance Misuse Team at Unity Mill is a gateway to Tier 4 services, in-patient detoxification or residential rehabilitation.

Clients who access residential rehabilitation will have tried various community options before, which have not been successful. They will also have to be committed to wanting to manage their alcohol issues, in order to stay the course. They will also have to move away from their home locality.

During 2006, so far only 3 clients have access residential rehabilitation.

In-patient detoxification may be part of a structured care plan. The Hospital-based Tier 4 service will only provide in-patient detoxification if they are referred by a Tier 3 service. We work closely with the nurse and doctors to ensure detoxification is part of a structured plan of care. This will hopefully prevent recurrent admissions to hospital.

Derby Hospitals NHS Foundation Trust at the City Hospital Derby provides an in-patient detoxification service, and the Mental Health Trust does provide that same service for clients with a mental health problem.

Tell us about your work with people in employment?

A Tier 2 service is vital for employers, to help catch people early in their experience of alcohol misuse, and to provide support to the employee, and sometimes to the employer too. We can offer out-of-hours appointments for people who work.

There is an advantage for people in work who have responsibilities – for some it is these responsibilities that may help them identify the need to overcome the adverse effects of alcohol.

We also work alongside employers, helping people with preparing and writing letters explaining they are not well. Indeed, we have had employers contact us directly and refer a member of their staff to us. We may try to arrange out of working hours sessions for the employee, so there is not an adverse affect to the employer.

Tell us about “wraparound” services?

Wraparound services such as access to social services, housing and debt management counselling and finding education and employments opportunities are really important for our clients.

In particular, some of our clients have difficulty with accessing sheltered accommodation – they may not be the “best” tenant if they have alcohol issues. We also have to raise awareness of this issue with Derbyshire Social Services workers.

However, if the main causes of clients' alcohol issues are not resolved, then they are more likely to return to our service in the future.

We have learned that Tier 3 clients can access clinical psychology services through Job Centre Plus, as part of getting them into employment. However, we cannot access this service, and Job Centre Plus has not been drawn into the wider range of professional services which oversees and manages people with alcohol issues.

How do you gather the views of clients in order to improve or shape your services?

The Mental Health Trust has a Substance Misuse Best Practice Group. The Group comprises a psychologist, nurses, pharmacists, drug and alcohol workers and two service users. It meets monthly.

The Group feeds in to the Mental Health Trust's Substance Misuse Care Service Team.

The Best Practice Group is used to inform the Care Service Team on what is current good practice. In 2005, the Group carried out a satisfaction survey amongst drug and alcohol clients. The Action Plan arising from the survey has yielded some good work, e.g. new protocols for alcohol withdrawal for in-patient services.

We also carry out a client satisfaction audit every year to gain client feedback about the service we offer and they receive.

APPENDIX 7

BREAKOUT – YOUNG PERSON'S SUBSTANCE MISUSE SERVICE IN SOUTH DERBYSHIRE

Staffing

1 wte Team Leader
2 wte Treatment workers
6 hrs sessional input from CAMHS Consultant
2 half time admin staff

} Not restricted to Alcohol work

What we do well

- Rapid access into service – assessment started within 5 days of referral
- Rapid access to treatment - treatment interventions started within 10 days of referral
- Client involvement in developing their treatment plan
- Multi-Agency working i.e. joint key working, use of partner agency premises to see clients etc.
- National recognition – featured in the National Treatment Agencies annual report 2003-2004
- Started oral Hep B/C testing
- Early identification of mental health issues (via consultant)
- Engage with ***very chaotic, hard to reach, vulnerable*** young people who have fallen 'through the net'.
- Involving and supporting parents in their child's treatment

What we need to improve on

- More consultant time
- Immunisations for Hep B
- Health checks i.e. liver function tests
- Access to appropriate housing for 16 to 18 year olds
- Tier 2 harm reduction work – new part-time workers have just come into post.

How we make contact with service users

- Free phone number for clients
- Telephone
- Text
- Letter
- Home Visit
- Joint agencies visit
- Appointments offered at times and locations agreed by client and key worker.

How we link with other agencies

- Close working with the Youth Offending Team, Connexions, CAMHS, Education, Youth Service, Social Services etc.
- Joint Multi-Agency working to client needs.

Relationship with Commissioners

- Good productive relationship with DAAT
- Have joint Joint Commissioning Group and Young People's Advisory Group meetings twice a year.

CLIENT STATISTICS 1/11/2005 TO 31/10/2006 (12 month period)

Overview

- Increase in drinking amongst females
- Alcohol often not seen or identified as a problem when clients referred for their drug use, but alcohol use is often also presents.

  - Clients where Alcohol is *primary* substance

Female Age 12 – 14	2
Male Age 12 – 14	0
Female Age 15 – 16	5
Male Age 15 – 16	3
Female Age 17 – 18	8
Male Age 17 – 18	10
Total clients	28

  - Clients where Alcohol is *primary* substance by PCT

Erewash	8
Amber Valley	12
Southern Derbyshire/Dales	8
Total clients	28

  - Clients where Alcohol is *secondary* use

Male	19
Female	13
Total	32